

UNITED STATES DISTRICT COURT  
EASTERN DISTRICT OF PENNSYLVANIA

RAFAEL RODRIGUEZ,	. Civil Action No. 16-1033
	.
Plaintiff,	.
	. U.S. District Court
vs.	. 101 Larry Holmes Drive
	. Easton, PA
PRIMECARE MEDICAL, INC. SUSAN,	.
RORBERTS, LPN, ALLISON YOUNG, RN,	. March 21, 2017
PAULA DILLMAN-MCGOWAN, CRNP,	. 10:08 a.m.
and ELIZABETH GARCIA, LPN,	.
	.
Defendants.	.

. . . . .  
.

TRANSCRIPT OF TESTIMONY OF DR. MICHAEL T. BROWN  
BEFORE HONORABLE EDWARD G. SMITH  
UNITED STATES DISTRICT JUDGE

APPEARANCES:

For the Plaintiff:       AFSAAN SALEEM, ESQ.  
                              THE RAMEAU LAW FIRM  
                              16 Court Street, Suite 2504  
                              Brooklyn, NY 11241  
                              (718) 852-4759  
                              [rameaulawny@gmail.com](mailto:rameaulawny@gmail.com)

For the Defendant:       JOHN R. NINOSKY, ESQ.  
                              JOHNSON DUFFIE STEWART & WEIDNER  
                              301 Market Street  
                              PO Box 109  
                              Lemoyne, PA 17043-0109  
                              (717) 761-4540  
                              [jninosky@johnsonduffie.com](mailto:jninosky@johnsonduffie.com)

Audio Operator:       Matt Sheetz  
TRANSCRIBED BY:       Valori Weber  
                              Weber Reporting Corporation  
                              2755 Commercial Street SE, #101-216  
                              Salem, OR 97302  
                              (970) 405-3643

Proceedings recorded by electronic sound  
Recording, transcript produced by transcription service.

**I N D E X****Page****WITNESS FOR THE PLAINTIFF**

DR. MICHAEL T. BROWN

Direct Examination by Mr. Saleem .....	3
Cross-Examination by Mr. Ninosky .....	172
Redirect Examination by Mr. Saleem .....	192
Recross-Examination by Mr. Ninosky .....	199
Further Redirect Examination by Mr. Saleem .....	200
Further Recross-Examination by Mr. Ninosky .....	202
Further Redirect Examination by Mr. Saleem .....	203

1           MR. SALEEM: We call Dr. Michael T. Brown, and he is  
2 outside, Your Honor.

3           THE COURT: Very well.

4           MR. SALEEM: Should we go get him or --

5           THE COURT: Yeah, if you would, please.

6           MR. SALEEM: Sure.

7           (Witness summoned)

8           THE COURT: Good morning, sir.

9           DR. BROWN: Good morning.

10          THE CLERK: Remain standing, raise your right hand.

11          Do you swear or affirm that the testimony you're about  
12 to provide in the issue now before this Court shall be the  
13 truth, the whole truth, and nothing but the truth so help you  
14 God?

15          DR. BROWN: I do.

16          THE COURT: Thank you very much, sir. And, sir, you  
17 may be seated. And, sir, would you please state your full name,  
18 spelling your last name for the record.

19          DR. BROWN: My name is Dr. Michael T. Brown, B-r-o-w-n.

20          THE COURT: Thank you very much, sir.

21          Counsel, you may proceed.

22          MR. SALEEM: Okay. Thank you, Your Honor.

23  
24 ///

1 DR. MICHAEL T. BROWN,  
2 a witness, having been first duly sworn, was examined and  
3 testified as follows:

4 DIRECT EXAMINATION

5 BY MR. SALEEM:

6 Q Good morning, Dr. Brown.

7 A Good morning.

8 Q Okay. And feel free, if you want, when I'm asking you  
9 questions, you can also just look to address the jury as well,  
10 okay? First off, Doctor, what type of doctor are you?

11 A I am a general and cancer surgeon.

12 Q Okay. And first off, can we just start by just describing  
13 to the jury your education starting with high school and where  
14 you attended?

15 A I grew up in Philadelphia. I graduated from West Catholic  
16 High School. I attended the University of Scranton. I did my  
17 medical school at Jefferson Medical College at Thomas Jefferson  
18 University. I graduated in 1986. I served a five-year general  
19 surgical residency at the Medical Center of Delaware. And I --

20 Q Doctor, I'm just going to cut you off.

21 A Okay.

22 Q We're going to get to that. You're just -- you're rushing  
23 ahead.

24 A Oh, okay.

25 Q You're skipping five questions ahead of me, which I

1 appreciate and I'm sure the jury would appreciate, but I think  
2 it's important just to kind of go through it a little bit  
3 slower, okay? So, first off, the high school you went to, you  
4 graduated in four years?

5 A Correct.

6 Q Okay. And then after that you went to the University of  
7 Scranton.

8 A Correct.

9 Q Okay. And then did you graduate with honors?

10 A Yes.

11 Q Magna cum laude?

12 A Yes.

13 Q Okay. And that was also four years.

14 A Correct.

15 Q And you got a degree in biology.

16 A Correct.

17 Q Okay. And then after you graduated college, did you attend  
18 medical school?

19 A I did.

20 Q Okay. And that was the Thomas -- the Jefferson University  
21 in Philadelphia?

22 A Jefferson Medical College in Philadelphia.

23 Q Sorry. And you received that degree after four years in  
24 1986.

25 A Correct.

1 Q Okay. And once you graduated medical school, are you a  
2 doctor?

3 A Yes.

4 Q Okay. And what -- after you go to -- finish going to  
5 medical school, what's the next line or training that you have  
6 to undergo as a doctor?

7 A You have to at least do an internship to receive a license.

8 Q What is an internship, Doctor?

9 A An internship is your first year out of medical school  
10 where you work in a hospital setting and are supervised.

11 Q And who are you supervised by?

12 A The attending physicians.

13 Q Okay. And do you also work alongside nurses when you're a  
14 -- as a first-year intern?

15 A Yes. Yes.

16 Q Okay. And after you finished the one year internship, do  
17 you go on for additional training?

18 A Yes. You can choose to do a residency in a certain medical  
19 specialty.

20 Q Okay. And what is a residency?

21 A A residency is a further defined period of training within  
22 a specialty. Certain specialties have different year  
23 requirements as to how many years you have to do.

24 Q Okay. And you were going for residency in general surgery?

25 A Correct.

1 Q And how long is the residency in general surgery?

2 A Including your internship, it's a five-year program.

3 Q Okay. And for that five years, what's happening during  
4 those five years? What are you doing?

5 A You're rotating through different aspects of general  
6 surgery and participating in operations and all phases of  
7 patient care in a supervised environment gradually taking on  
8 more and more responsibility.

9 Q Okay. But you're actually engaging in patient care during  
10 those five years?

11 A Correct.

12 Q Okay. And you're actually serving as the patient's doctor  
13 during that time?

14 A Correct.

15 Q But you're also being supervised by more experienced  
16 doctors, is that fair to say?

17 A Correct. Yes.

18 Q Okay. Now, did you stop your training after you received  
19 your five-year -- finished your five years in residency in  
20 general surgery?

21 A No.

22 Q Okay. What additional training did you get?

23 A Then I served what is known as a fellowship.

24 Q What's a fellowship, Doctor?

25 A A fellowship is additional training after your residency.

1 Q Okay. And why did you go for that additional training?

2 A Because I wanted to subspecialize.

3 Q Okay. And when you say subspecialize, what do you mean?

4 A Well, many specialties today then subspecialize because of  
5 the complexity of medicine. So after I performed five years of  
6 general surgery, I then chose to subspecialize in the area of  
7 cancer surgery.

8 Q I see. Okay. And how long was that fellowship training?

9 A One year.

10 Q Okay. And did that conclude your training?

11 A Yes.

12 Q Okay. Did you go for any additional degrees?

13 A Yes.

14 Q What additional degrees did you go for?

15 A I have an MBA in healthcare from Alvernia University.

16 Q And how long was that, the MBA course?

17 A That was a two-year program. I graduated in 2007.

18 Q Okay. And why did you go for -- why did you decide to get  
19 an MBA?

20 A Well, I've taken on more leadership responsibilities and  
21 the MBA was offered through the Pennsylvania Medical Society and  
22 Alvernia University. I serve as the medical director of McGlinn  
23 Cancer Institute.

24 Q Okay. And, Doctor, just if we can do the math here, in  
25 terms of the years of training that you have had, you went

1 through four years of college, right?

2 A Correct.

3 Q And then you had four years of medical school.

4 A Correct.

5 Q And then you had five years of residency in general  
6 surgery.

7 A Correct.

8 Q And then you had an additional year in fellowship in  
9 surgical oncology.

10 A Correct.

11 Q Okay. So just doing the math here, 4 plus 4 is 8, plus 5  
12 is 13, plus 1 is 14, 14 years of medical training?

13 A Correct.

14 Q Okay. And an additional two years of training for the MBA.

15 A Correct.

16 Q Okay. And once you -- now, additional to your fellowship,  
17 are you licensed to practice medicine in the State of  
18 Pennsylvania?

19 A I am.

20 Q Okay. And in addition to your license, do you have any  
21 certifications?

22 A I do.

23 Q And, first of all, what is a certification? How is it  
24 different than a license?

25 A A certification is certified by certain organizations. And

1 in medicine, we take medical boards. So you take generalized  
2 boards to get your license and then you take specific boards to  
3 be board certified within your specialty.

4 Q Okay.

5 A So I am board certified in surgery through the American  
6 College of Surgeons, so I have letters after my name, and Fellow  
7 of the American College of Surgeons.

8 Q Okay.

9 A That's the highest accreditation you can get in your field.

10 Q And do all doctors or all surgeons -- are all surgeons  
11 board certified?

12 A No, not necessarily.

13 Q Okay. What do you have to do to become board certified?

14 A You have to be in practice for two years. You have to take  
15 a written examination. And then a year later after your written  
16 examination you have to take an oral examination. You have to  
17 take a written test every ten years and you must submit ongoing  
18 CME credits, 150 hours every 2 to 3 years to maintain your board  
19 certification.

20 Q And when you say oral examination, what do you mean by oral  
21 examination?

22 A Oral examination is where you go through a set of question  
23 and answers through a board of senior experienced surgeons.  
24 They ask you different scenarios in general surgery.

25 Q So it's a fairly intensive process to become board

1 certified?

2 A Quite.

3 Q Okay. You mentioned the term CME. What's CME?

4 A Oh, CME stands for Continuing Medical Education. One  
5 credit is one credit hour. That means you need 150 hours every  
6 couple years.

7 Q Okay. So despite the fact that you had 14 years of medical  
8 training you still are undergoing -- you're required to undergo  
9 training?

10 A All the time.

11 Q Okay. And you say you're board certified by the American  
12 Board of Surgery. Do you also have certification from the  
13 National Board of Medical Examiners?

14 A Yes.

15 Q And what is that board?

16 A That board is the general board that when you finish your  
17 medical school and your first year of internship, you're able to  
18 get a license to practice medicine in the State of Pennsylvania.  
19 It's a general board examination covering the entire realm of  
20 medicine that you're able to write prescriptions independently.

21 Q I see. Okay. And do you also have any certifications from  
22 the American College of Surgeons in terms of advanced trauma  
23 life support?

24 A Right. Well, I was an instructor in advanced trauma life  
25 support. I'm no longer an instructor. I don't participate in

1 trauma surgery. I'm also a member of the Society of Surgical  
2 Oncology and some other related societies, Society of  
3 Gastrointestinal Surgeons, American Society of Clinical  
4 Oncologists, and the American Society of Breast Surgeons.

5 Q I see. Okay. And, Doctor, have you held any teaching  
6 positions?

7 A I do.

8 Q You do. Okay. Do you currently hold any teaching  
9 positions?

10 A Yes, I do.

11 Q What teaching positions do you currently hold?

12 A I'm on the clinical faculty of Philadelphia College of  
13 Osteopathic Medicine. I'm a preceptor for King's College in  
14 Wilkes-Barre. I'm a member of the Cancer Center at Thomas  
15 Jefferson University in Philadelphia, the Kimmel Cancer Center.  
16 And we have our own teaching programs at the Reading Hospital.

17 Q Okay. You used the term preceptor. What's a preceptor?

18 A Preceptor is where you're an instructor for students going  
19 through the program.

20 Q Okay. And how long have you held those teaching positions?

21 A More than a decade.

22 Q Okay. And have you served on any committees?

23 A Yes.

24 Q What committees have you served on?

25 A I'm currently the chairman of the cancer committee at the

1 hospital. I am the cancer liaison officer of Reading Health  
2 System to the American College of Surgeons. And I have served  
3 as head of the nutrition committee and I am serving as the chief  
4 of general surgery right now.

5 Q Okay. And yeah, you just -- you led into my next question.  
6 What current clinical positions do you hold?

7 A Section chief of general surgery.

8 Q What does it mean to be sectional chief?

9 A Section chief means that you provide meetings and ongoing  
10 meetings for the other general surgeons within your section. We  
11 have approximately 15 surgeons in our section and we go over  
12 things that are happening in the hospital and I have to sign off  
13 the credentials of the surgeons. We follow any new procedure of  
14 how we would credential those procedures. And we look at things  
15 going on within our section and then we have section meetings  
16 within the entire department of surgery, how the hospital  
17 functions, how the section works with other sections.

18 Q And what is credentialing?

19 A Credentialing is how we make sure that the physician or  
20 surgeon is adequately trained to do the procedure they may want  
21 to do.

22 Q Okay. And as a section chief, you're overseeing -- is it  
23 fair to say you're overseeing the work of or are responsible for  
24 15 other surgeons?

25 A Correct.

1 Q Okay. And how long have you held that position?

2 A More than five years. Approximately seven years.

3 Q Okay. Thank you.

4 MS. RAMEAU: Your Honor, may we approach?

5 THE COURT: Certainly. Counsel, please approach.

6 (Sidebar)

7 MS. RAMEAU: What I notice is that one of the jurors  
8 is falling asleep. It's the one with grey hair. I can't recall  
9 his name. He was falling asleep, but when I said, "Can we  
10 approach," he sort of woke up. I think maybe --

11 MR. SALEEM: (Inaudible).

12 (End of Sidebar)

13 THE COURT: Ladies and gentlemen, we are going to  
14 stand in recess for 15 minutes. I'm going to again caution you.  
15 You should keep an open mind about this case until all the  
16 evidence is in on both sides, so you should refrain from  
17 discussing it with each other or with anyone else, including  
18 members of your family or allow anyone to talk to you about it.  
19 Do not form any opinions about this case until you retire to the  
20 jury room after my charge.

21 We'll stand in recess for 15 minutes.

22 THE BAILIFF: All rise.

23 (Recess taken at 10:22 a.m.)

24 THE COURT: Mr. Saleem, you may continue, sir.

25 DIRECT EXAMINATION CONTINUED

1 BY MR. SALEEM:

2 Q Great. Thank you, Your Honor. Doctor, have you published  
3 any articles?

4 A Yes.

5 Q About how many articles or in what subject areas did you  
6 publish those articles? And now these articles are --

7 A Four or five in cancer related fields.

8 Q Okay.

9 A Sarcomas, liver cancer, colon cancer.

10 Q Okay. Thank you. And these are in publications that would  
11 you -- in medical journals and presented or were they presented?

12 A They're in medical journals and in some textbooks.

13 Q Okay. Great. And at this time, Your Honor, I would like  
14 to offer Dr. Brown as an expert in the field of general surgery.

15 THE COURT: Okay. So, Mr. Ninosky, do you have any  
16 questions on qualifications?

17 MR. NINOSKY: Just a few, Your Honor.

18 THE COURT: Very well. You may proceed, sir.

19 MR. NINOSKY: Thank you.

20 VOIR DIRE EXAMINATION

21 BY MR. NINOSKY:

22 Q Doctor, I just have a few questions for you and I'll be  
23 candid with you. It's because I have to get some things out,  
24 okay.

25 A Fine.

1 Q You have never worked in a prison.

2 A No.

3 Q You never have provided any sort of correctional  
4 healthcare.

5 A Well, I have treated prisoners throughout my career.

6 Q Correct. But you have never been working in a correctional  
7 facility providing care.

8 A Correct.

9 Q You have never reviewed policies or procedures.

10 A Correct.

11 Q You have never formulated policies or procedures.

12 A Correct.

13 Q And, in fact, you never even reviewed them in this  
14 particular case.

15 A Correct.

16 Q And, sir, you don't even think you're qualified to give an  
17 opinion as to --

18 MS. RAMEAU: Objection.

19 THE COURT: Counsel, please approach. And I need a  
20 basis when you have an objection.

21 (Sidebar)

22 MS. RAMEAU: (Inaudible).

23 MR. SALEEM: We're not offering him as an expert in  
24 that. We're offering him as an expert in general surgery. So  
25 whether or not (inaudible).

1 MS. RAMEAU: (Inaudible) qualifications to offer as an  
2 expert in the field of general surgery. This is beyond the  
3 scope of (inaudible).

4 MR. NINOSKY: (Inaudible).

5 THE COURT: (Inaudible).

6 MR. NINOSKY: Well, to get this back to, the Court  
7 hasn't rule on our motion for the Monell portion of this case.  
8 I'm trying to establish a record. They don't have an expert who  
9 can give any testimony as to policies or procedures. So, to me,  
10 I'm doing this so that I can come to you and say, "Your Honor,  
11 based upon his lack of experience, the Monell portion of the  
12 case should be over. There's not going to be any testimony as  
13 to that because they don't have a qualified expert to give any  
14 such testimony."

15 THE COURT: So your question to him (inaudible).

16 MR. NINOSKY: I was going to ask him, "You don't even  
17 feel qualified to be able to give an opinion as to policies and  
18 procedures for correctional healthcare."

19 THE COURT: I'll overrule the objection. Ask the  
20 question.

21 MR. NINOSKY: And the only other thing I ask is I want  
22 to know which lawyer is going to be involved. You can do it by  
23 witness. I don't care. But he's asking questions and now she's  
24 making objections. I don't appreciate being tag teamed. You  
25 know, one at a time, please, respectfully if we can give that

1 instruction.

2 MS. RAMEAU: But, Your Honor, and I don't want to  
3 confuse the jury with this. I think if we create an  
4 instruction, that might be inappropriate.

5 MR. NINOSKY: Well, here's how we fix it. Do you  
6 withdraw the Monell claim against PrimeCare? If you withdraw  
7 that claim right now with prejudice I'm not going to ask any  
8 more questions about it.

9 MS. RAMEAU: (Inaudible). Your Honor, we'll withdraw  
10 it and we want an instruction that the jury is not to consider  
11 any response from this.

12 THE COURT: (Inaudible).

13 MS. RAMEAU: (Inaudible).

14 MR. NINOSKY: Well, now, respectfully, I disagree and  
15 here's why. We only got the dismissal now. It was certainly  
16 proper to ask those questions. I don't want this jury to think  
17 I was asking -- going down an improper line of questioning.

18 THE COURT: (Inaudible).

19 MR. NINOSKY: And there would be no more questions.  
20 And then I'm not going to object to him as a general surgeon.

21 MS. RAMEAU: Okay.

22 (End of Sidebar)

23 THE COURT: Ladies and gentlemen, Counsel have come to  
24 an agreement that the issue of the prison's policies and  
25 procedures is no longer an issue in this case, so you can

1 disregard the questions regarding the policies and procedures  
2 that were in place at the prison regarding medical care.

3 Is that instruction satisfactory to the Plaintiffs?

4 MR. SALEEM: Yes, Your Honor.

5 THE COURT: And satisfactory to the Defense?

6 MR. NINOSKY: And with that, Your Honor, I have no  
7 objection to the tender and I have no further questions of the  
8 witness at this time.

9 THE COURT: Very well. Without objection, Dr. Brown  
10 is accepted as an expert in general surgery.

11 Mr. Saleem, you may continue, sir.

12 MR. SALEEM: Thank you, Your Honor.

13 DIRECT EXAMINATION CONTINUED

14 BY MR. SALEEM:

15 Q Doctor, have you ever been qualified as an expert before to  
16 testify at trial?

17 A I have.

18 Q On how many occasions have you been qualified as an expert?

19 A Three or four.

20 Q Okay. And of those times that you were qualified, on how  
21 many occasions did you serve as an expert on the side of the --  
22 withdrawn. And in what types of cases did you serve as an  
23 expert?

24 A I served as an expert for other physicians in cases and for  
25 the hospital in a case.

1 Q And when you say other physicians in cases and the hospital  
2 in cases, those are cases in which the hospital and physicians  
3 were being sued?

4 A Correct.

5 Q So you were a Defendant on behalf of the Defendants?

6 A Correct.

7 Q I mean an expert on behalf of the Defendants.

8 A Correct.

9 Q Okay. Doctor, how many times have you testified as an  
10 expert on behalf of an injured person or a patient?

11 A I have never testified on behalf of --

12 Q Okay. So this is the first time you're testifying --

13 A Correct.

14 Q -- as on behalf of someone who's been injured?

15 A Yes.

16 Q Okay. And what about this case, Doctor, that made you  
17 decide to testify in this case as an expert?

18 A I thought there was a breach in the standard of care.

19 Q Okay. Okay. And, Doctor, in this case also you also  
20 served as the treating doctor for Mr. Rodriguez, is that  
21 correct?

22 A I did.

23 Q Okay. So you were actually the surgeon who performed the  
24 appendectomy, right?

25 A Yes.

1 Q And also you have performed a subsequent surgery on behalf  
2 of Mr. Rodriguez, is that right?

3 A Correct.

4 Q Okay. And did you also continue to treat him while he was  
5 being -- while he was staying at Reading Hospital?

6 A Yes.

7 Q Okay. And, Doctor, and do you currently maintain a  
8 surgical practice?

9 A Yes.

10 Q Okay. In an average week, about how many surgeries would  
11 you perform?

12 A Fifteen to twenty.

13 Q Okay. And how often would you see patients during the  
14 week?

15 A Every day.

16 Q Okay. Do you have any plans to see any patients today?

17 A I already performed an operation this morning.

18 Q You performed an operation this morning?

19 A Correct.

20 Q What operation did you perform this morning?

21 A A partial mastectomy for breast cancer.

22 Q Okay. And then you came here to testify.

23 A Correct.

24 Q Okay. Doctor, are you being compensated for your time away  
25 from your practice?

1 A I am.

2 Q Okay. And how are you being compensated? What is your  
3 rate of compensation?

4 A Three hundred and fifty dollars an hour.

5 Q Okay. And have you also been -- what, if anything, did you  
6 do to prepare for your testimony here today?

7 A I have reviewed the records at the hospital and the records  
8 of the prison.

9 Q Okay. And are you also -- have you been compensated or are  
10 you expecting to be compensated for that time that you spent  
11 reviewing the records?

12 A Yes.

13 Q Okay. Which was it? Have you been compensated or you're  
14 expecting to be compensated?

15 A Expecting to be compensated.

16 Q Okay. And have you and I met before today?

17 A Last night.

18 Q Okay. And when was the first time that we met before  
19 today?

20 A Last night.

21 Q Last night. I'm sorry.

22 A Correct.

23 Q I didn't hear that. Okay. Okay. And have you ever worked  
24 with my firm before?

25 A Never.

1 Q Okay. All right. Doctor, now let's -- I want to start  
2 talking a little bit into this case is about an appendix. Let's  
3 try to like educate the jury as to what it is. First off, can  
4 you just define what an appendix is?

5 A An appendix is a tube like structure that occurs off of the  
6 beginning of the colon. We call it the cecum. It's in the  
7 right lower aspect of the abdomen.

8 Q Okay.

9 A It's about as long as your finger.

10 Q Okay.

11 A It can vary in size.

12 Q Okay. I'm going to stop you, Doctor. Sometimes a picture  
13 is worth 1,000 words. So let me just first off --

14 MR. NINOSKY: No objection.

15 MR. SALEEM: Your Honor, I'd just like to show the  
16 witness and also -- that's about it, Your Honor.

17 THE COURT: And there's no objection to this being  
18 published to the jury?

19 MR. NINOSKY: No, Your Honor.

20 THE COURT: And do you want to mark that as a --

21 MR. SALEEM: Yes. Can we mark this as Plaintiff's  
22 Exhibit 1?

23 THE COURT: Very well. And without objection,  
24 Plaintiff's Exhibit 1 is admitted into evidence and may be  
25 published to the jury.

1 (Plaintiff's Exhibit 1 admitted)

2 MR. SALEEM: Great. Thank you, Your Honor.

3 BY MR. SALEEM:

4 Q And I'm just going to show you -- if it's not clear,  
5 Doctor, can you tell me? Because I want to make sure it's clear  
6 to the jury as well. Is that in focus?

7 A Not quite. That's good.

8 Q That's better, right? Okay. It's not an eye exam. I just  
9 want to make sure. Okay. Doctor, I think you just mentioned  
10 something about quadrants. Based on the diagram here -- and,  
11 Your Honor, if it's permissible for the witness, if he could  
12 step off and point to the document, if that's permissible.

13 THE COURT: Certainly. That would be fine.

14 BY MR. SALEEM:

15 Q Great. Thank you. So, Doctor, can you just look at the --  
16 there's two figures on the screen. What is the difference  
17 between the two figures?

18 A The first figure breaks the abdomen down into a little bit  
19 more specific areas. Generally, we use this figure to break the  
20 abdomen down into four quadrants.

21 Q And when we say this figure, just for the record, we're  
22 talking about the right figure.

23 A Correct.

24 Q Okay. And what comprises the abdomen?

25 A The abdominal cavity is your bowel. It's divided by

1 diaphragm, which separates the lungs and chest and the heart.  
2 It's called the diaphragm. And below is the pelvis and along  
3 the side walls are your muscles of the abdominal cavity.

4 Q Okay. And what is in -- can you just go through the  
5 different quadrants and what organs or what you expect to find  
6 in the different quadrants?

7 A Yeah. Your esophagus comes down through the chest and then  
8 you have your stomach. Then you have 20 feet of small intestine  
9 which enters the colon or your large intestine in the right  
10 lower quadrant. The appendix comes off of the colon. The colon  
11 goes up, around, down, and enters the rectum. Behind it, you  
12 have the liver, the gall bladder here. In the back, you have  
13 the two kidneys. You have your bladder up right there in the  
14 front.

15 Q And where is the appendix generally found?

16 A Generally found in the right lower quadrant.

17 Q Okay. Are there times that the appendix is located in  
18 different areas?

19 A It can. It can be sometimes wrapped behind the colon and  
20 can be pointing into the right upper quadrant. It can sometimes  
21 be very deep in the pelvis. It can, in some patients that have  
22 a very floppy colon, it could actually be over into the left  
23 side.

24 Q Okay. And, Doctor, don't sit down too quickly. I'm just  
25 going to show you what's been -- a book called *Atlas of Human*

1 Anatomy by Frank Netter. Have you heard of this book?

2 A Yes.

3 Q Okay. And is this -- how have you heard of this book?

4 A It's a standard.

5 Q Okay. And it's standard in the field of medicine and  
6 surgery?

7 A In medicine.

8 Q Okay. I'm just going to show you -- so it's an  
9 authoritative text, Doctor?

10 A Yes.

11 Q Okay. And I'm just going to show you a page from there,  
12 which is labeled plate 275. And I'm just looking at this  
13 diagram, Doctor. This is a diagram right here of the human  
14 body. What does that diagram show?

15 A It shows the abdominal cavity and it shows possible  
16 positions of the appendix (inaudible).

17 Q And just, I don't know if you can overlay the other picture  
18 or not, but are there situations then that the appendix could be  
19 located in areas other than the right lower quadrant?

20 A Correct. It could be mostly in the right lower quadrant,  
21 but at times it could be in the right upper quadrant or even  
22 across the midline into the left lower quadrant.

23 Q Okay. And is there any way to know for a patient where  
24 their appendix is located just by looking at them?

25 A No.

1 Q And, Doctor, just while we have this page open, what is  
2 this picture right here?

3 A This is a picture of the small intestine and the colon and  
4 the colon, the beginning of the colon called the cecum. This is  
5 a retrocecal appendix, meaning the appendix is actually behind  
6 the cecum.

7 Q Okay. And what is then this black and white image on the  
8 top?

9 A Yeah. This is contrast. So the patient was given barium.  
10 That shows up on film. And so you can see a particularly long  
11 appendix.

12 Q Okay.

13 A It's a very long appendix.

14 Q And I'm going to show you now, Doctor, this image, but it's  
15 called plates 274. What does this image depict?

16 A This depicts opening of the colon, the small intestine  
17 entering into the colon, and you have an opening into the  
18 appendix. The appendix is a hollow tub structure and it has an  
19 opening.

20 Q And I'm just going to show you one more. This is on plate  
21 276. What does this diagram depict, Doctor?

22 A This is the colon that frames the abdomen. So you have the  
23 right lower quadrant with the appendix. You have the right  
24 colon, the transverse colon, the left colon, the sigmoid colon,  
25 which is S-shaped entering into the rectum.

1 Q And this is a two-page diagram that spills from plate 314  
2 to 315, well, both 314, actually. What are we looking at here  
3 in this diagram, Doctor?

4 A This is a diagram demonstrating the nerves of the  
5 intestine. And it shows you the majority of the small intestine  
6 and right colon, the nerves go back and join T10 in the spine.  
7 And T10 is the general area where you would feel pain around  
8 your belly button. So any inflammation going in this area you  
9 would most likely proceed it as being pain in and around your  
10 naval and umbilicus.

11 Q Okay. What was the last term you used, Doctor? Bilicus?

12 A Umbilicus.

13 Q Umbilicus. What does that word mean?

14 A Naval, belly button.

15 Q Okay. All right. Great. Thank you, Doctor. And what  
16 function does the appendix serve?

17 A It's unknown what function the appendix serves. It has  
18 lymphoid tissue. Lymphatic tissue can help with certain  
19 infections, but the true nature of the appendix is unknown.

20 Q Can someone survive without an appendix?

21 A Yes. Quite well.

22 Q Okay. Okay. Now, Doctor, in your practice have you had  
23 patients come to you or present to you with abdominal pain?

24 A Yes.

25 Q Okay. And when they present to you with abdominal pain are

1 there certain things or measures that you take when someone  
2 presents to you with abdominal pain?

3 A Yes.

4 Q Now what are -- and when you were talking about abdominal  
5 pain, are there a range of diagnosis or conditions that could  
6 lead to abdominal pain?

7 A Yes, there are several.

8 Q Okay. Have you heard the term differential diagnosis?

9 A Yes.

10 Q Can you just describe to the jury what it means, what a  
11 differential diagnosis is, the term?

12 A A differential diagnosis is a preliminary diagnosis and  
13 it's what are the different medical conditions that you would be  
14 considering in abdominal pain. What's your number one, your  
15 number two, your number three consideration of what's going on  
16 with the patient.

17 Q Okay. And what is the purpose in or what is the reason for  
18 having those differential diagnosis?

19 A So that you can then narrow your focus on further  
20 evaluation. You know, so you can rule in number one or rule it  
21 out. Move on. Rule in number two or rule it out.

22 Q And we have -- we talked about differential diagnosis. Is  
23 it a range in terms of what could possibly happen to the person  
24 or as a result of the abdominal pain?

25 A Yes.

1 Q Okay. And when you are doing a differential diagnosis, do  
2 you start it anywhere in terms of severity?

3 A Yes.

4 Q Where would you start?

5 A The most severe condition.

6 Q Okay. And so when you say the most severe condition, is  
7 that something that you would want to first -- is that the first  
8 thing you want to figure out, if the person has that or not?

9 A Yes.

10 Q Okay. And why is it important to start with the most  
11 severe condition?

12 A Because usually they're time sensitive.

13 Q What do you mean by time sensitive?

14 A Well, if they need to be -- the patient will deteriorate,  
15 become worse if you don't make that diagnosis and take  
16 corrective action.

17 Q Okay. So you want to first establish whether or not the  
18 person has the most severe thing. And then you used the term  
19 rule out. What do you mean by rule out?

20 A Rule out is to evaluate and either, you know, consider  
21 further or decide that, no, that condition is not in play in  
22 this patient.

23 Q Okay. So you want to first -- when at first someone  
24 presents to you with abdominal pain, is it fair to say that  
25 everything is initially on the table?

1 A Usually.

2 Q Okay. So you would start out, the cup -- I think you  
3 weren't here for this, but during opening arguments this was  
4 used. So is it fair to say that you first think about all the  
5 possibilities first in terms of coming up with a diagnosis?

6 A Correct.

7 Q Okay. You're not going to start at the bottom, right?

8 A Correct.

9 Q Okay. Because if you start from the bottom, when you start  
10 from the bottom, that means you're limiting yourself, right?

11 A Correct.

12 Q Okay. So you want to first figure out what the problem is  
13 and then narrow it down and ultimately come up with the correct  
14 diagnosis, is that right?

15 A Correct.

16 Q Okay. Because I think, as you said, it's important. Time  
17 is a factor, is that fair to say?

18 A Correct.

19 Q Okay. So if you -- what could possibly happen, Doctor, if  
20 you start out, limit yourself to a different diagnosis and then  
21 be proven wrong?

22 A The patient's condition could deteriorate.

23 Q Okay. And let's just talk specifically about abdominal  
24 pain. What are the different differential diagnosis for  
25 abdominal pain?

1 A There could be many, many conditions.

2 Q But what's --

3 A I'll go over the most common ones.

4 Q Let's just start, if you could, from the strengths, from  
5 the highest to the lowest, Doctor.

6 A Well, the highest abdominal complaint would be someone who,  
7 you know, has pain all over their abdomen and who has imaging  
8 studies that demonstrate free air. That's a term we use where  
9 there's air outside of the intestine where it shouldn't be  
10 around the liver or around any of the organs. And that  
11 signifies that there's a perforation of an organ.

12 Q And, okay. And what are the other types of possible  
13 differential diagnosis?

14 A The free air could be -- it could be associated with a  
15 perforated ulcer, perforated diverticulitis, which is  
16 inflammation of the left colon. And even in appendicitis you  
17 can have gall bladder disease. That's very common usually in  
18 the right upper quadrant. Diverticulitis is very common.  
19 Urinary tract infection, inflammation of the stomach, gastritis,  
20 and you can even present with abdominal pain with kidney stones  
21 on one side or the other.

22 Q You mentioned a lot there, Doctor.

23 A Right.

24 Q I just want to kind of go through a little bit of it. What  
25 are the potential complications of a perforated liver, a

1 perforated ulcer if it's not properly diagnosed?

2 A The patient would develop peritonitis and go on to become  
3 very, very sick.

4 Q And when you say very, very sick, what do you mean?

5 A Well, peritonitis is inflammation of the entire abdominal  
6 cavity.

7 Q So what we were looking at before -- I don't know if this  
8 picture helps or not. Does this diagram help or would a  
9 different one help, Doctor?

10 A No, that one helps.

11 Q This one helps?

12 A Right.

13 Q Okay. When you say entire abdominal cavity, just what --

14 A In more than one quadrant.

15 Q Okay.

16 A You would be seeing inflammation in more than one quadrant.

17 Q Okay.

18 A So usually we talk about either localized inflammation or,  
19 you know, non-localized inflammation.

20 Q Okay. And that's just one possible outcome of and one  
21 potential differential diagnosis for someone presenting with  
22 abdominal.

23 A Correct.

24 Q Now you also mentioned diverticulitis which is also -- I  
25 think you said it's a perforated colon.

1 A Correct.

2 Q What is the significance of the perforated colon?

3 A Again, you can get a localized abscess in diverticulitis.  
4 That can be commonly in the left lower quadrant, but can also be  
5 centrally located. And when you perforate the colon it spills  
6 bowel movement into -- which is teeming with bacteria, and you  
7 can either get a localized abscess or you could get inflammation  
8 throughout the abdomen.

9 Q Okay. You used a couple of terms there. I'm trying to  
10 make sure we're on the same page. What does perforated mean?

11 A Perforated means that you get a hole.

12 Q Okay. And the term abscess, what is that?

13 A Abscess is a pocket full of puss.

14 Q Okay. And what about inflammation? What does that mean?

15 A Inflammation is swelling of the tissue. Inflammation can  
16 be associated with infection or just inflammation of the tissue  
17 from other factors.

18 Q Okay.

19 A Appendicitis and diverticulitis is associated with  
20 infection. A perforated ulcer initially is just associated with  
21 the inflammation of the stomach and then secondarily gets  
22 infected.

23 Q Okay. And you also mentioned complications with the gall  
24 bladder. What potential outcome can happen as a result of that,  
25 if that's not diagnosed properly?

1 A You can go on to get gangrene of the gall bladder. The  
2 gall bladder can actually die. You can become very sick from  
3 it.

4 Q And what's gangrene?

5 A Gangrene is when the tissue gets so swollen, or edema, it  
6 squashes its blood supply and then it actually starts to die and  
7 the tissue dies.

8 Q Okay. And what's gastritis?

9 A Gastritis is inflammation of the stomach.

10 Q Compared to that, is that on a lower level in terms of  
11 differential diagnosis, in terms of severity or if you can just  
12 explain?

13 A Yes. Generally gastritis is not as severe as, you know, a  
14 perforated stomach.

15 Q Okay. And what is gastritis exactly?

16 A Gastritis is inflammation of the lining of the stomach.

17 Q And how can someone get gastritis?

18 A You can get it a couple of different ways. You can get it  
19 -- you can pick up an infection that can cause it. Some people  
20 are prone to gastritis through either a stomach virus. You can  
21 get it with irritation of medications.

22 Q Okay. And if someone is presenting with -- withdrawn. And  
23 how would you go about ruling out the different differential  
24 diagnosis, the ones that you just described to us?

25 A Generally, we use a combination of physical examination,

1 history and physical examination, laboratory values, and imaging  
2 studies.

3 Q Okay. Now in your practice do you -- are you the first  
4 person that would see the patient or have they already been seen  
5 by other medical professionals usually?

6 A Usually they've been seen by other medical professionals.

7 Q And if someone is presenting in a hospital setting and they  
8 go to the emergency room, who would then tend to first come into  
9 contact with?

10 A The triage nurse and the emergency room physician.

11 Q Okay. And the nurses, would they be either what's called  
12 RNs, registered nurses, or LPNs?

13 A RNs.

14 Q Okay. Would there be LPNs at all or no, as far as you  
15 know? Licensed Practical Nurses?

16 A I'm not sure that there are LPNs in the emergency room at  
17 this point.

18 Q Okay. And when the nurses first -- and do the nurses --  
19 when you say triage, what do you mean by triage?

20 A Triage.

21 Q Triage, sorry.

22 A Triage is a word of just sorting out how sick the patient  
23 is so that if somebody comes in with severe abdominal pain that  
24 the nurse would recognize that they get moved up and be seen.  
25 And if somebody comes in and the nurse feels that they're not

1 that sick, then they'll be put in a different queue or line to  
2 be evaluated.

3 Q And how would a nurse go about doing that, making that  
4 assessment or making that decision?

5 A They would talk to the patient. They would examine the  
6 patient, have the history.

7 Q Okay. And when you say talk to the patient, is that to  
8 obtain what's called a history?

9 A Yes.

10 Q Okay. That's a history of the complaint?

11 A Correct.

12 Q Okay. And in addition to talking with the patient, what is  
13 the nurse looking for when they are conducting that history?

14 A They're looking for the overall patient's demeanor. Does  
15 the patient look sick?

16 Q All right. And what significance is it to actually look at  
17 the patient as opposed --

18 A Oh, I'm sorry. Okay. Turn it off.

19 Q Let me just -- I didn't finish asking the question.

20 A Yeah. I'm sorry.

21 Q And what significance is it to actually look at the  
22 patient?

23 A It's very significant.

24 Q Why?

25 A Well, because a picture is worth a thousand words.

1 Q Okay.

2 A You can look at a patient and you can get a good assessment  
3 as to whether this patient is sick or this patient does not look  
4 too sick from a medical standpoint.

5 Q And of what significance is the -- withdrawn. And the  
6 history. Is it fair to say that some patients are better able  
7 to give a history as others?

8 A Yes.

9 Q And what are some of the limitations that could come into  
10 play as to why someone may not be able to give as good a history  
11 as other people?

12 A Well, education level, the authority to express yourself,  
13 you know, your vocabulary level all come into play as to be able  
14 to express, age generally. You know, an adult can express  
15 themselves better than a child in exactly what's going on.

16 Q And are these sorts of things that nurses are trained to  
17 take into account when they're taking a history?

18 A Yes.

19 Q And I think you mentioned age. So is it fair to say that  
20 the history presented by a 6 year old may differ from the  
21 history presented by, say, a 30 year old person?

22 A Correct.

23 Q And thank you so much. So they conduct a history. They --  
24 and which is examining -- let me start over. Aside from taking  
25 the history, you mentioned a physical exam.

1 A Right.

2 Q How would a nurse go about conducting a physical exam?

3 A The nurse --

4 Q Would nurses conduct physical exams?

5 A No. They would defer that to the physician.

6 Q Okay. So what information is the nurse being provided with  
7 to make a decision as to whether or not to go to a physician?

8 A To take the history and they would take the initial vital  
9 signs.

10 Q Okay. Now, you mentioned vital signs. Let's just talk for  
11 a second. Are there -- what are the vital signs?

12 A The vital signs are temperature, pulse, blood pressure, and  
13 your rate of breathing.

14 Q Okay. And what significance are the vital signs as part of  
15 your assessment of the patient?

16 A They're significant. They're more significant as they  
17 become more abnormal.

18 Q Okay. Okay. And just for -- withdrawn. Okay. Now, are  
19 there certain guideposts to diagnose appendicitis?

20 A There are.

21 Q Okay. And what are general guideposts to come up with a  
22 diagnosis of appendicitis?

23 A Take the history first.

24 Q Okay.

25 A And the general history of appendicitis is starting with

1 abdominal pain.

2 Q Okay. And does it -- abdominal pain in any particular  
3 area?

4 A The pain is usually described as periumbilical or centrally  
5 located within the abdomen.

6 Q Okay. Okay. And have you conducted physical examinations  
7 of abdominal examinations?

8 A Yes.

9 Q About how many have you conducted in your career?

10 A Thousands.

11 Q And have you treated patients with appendicitis?

12 A Yes.

13 Q About how many have you treated in your career?

14 A Hundreds.

15 Q And have you performed surgeries regarding the appendix?

16 A Yes.

17 Q How many have you performed?

18 A Hundreds.

19 Q Okay. And when you perform those surgeries are there  
20 different -- are there two different types of surgeries? Is  
21 there something called a laparoscopy versus an open abdomen?

22 A There is.

23 Q What is a laparoscopy?

24 A Laparoscopic surgery is when we put a small TV camera  
25 usually through the belly button and then we put in two other

1 small little incisions and we put in two little tubes to put our  
2 working instruments in. And we're able to take the appendix out  
3 through the belly button. It's called minimally invasive  
4 surgery.

5 Q So if you could just, if you don't mind, Doctor, just  
6 demonstrate where you would on your own body, if you could,  
7 perform those incisions on the patient.

8 A The TV camera goes through the belly button. And since the  
9 appendix is located in the right side, the surgeon works from  
10 the left side of the abdomen. And two --

11 Q I'm sorry. Why is that?

12 A So that you have room to go across the abdomen. If you  
13 came in on the right side you would be right on the appendix.  
14 You wouldn't have any working room.

15 Q I see. Okay.

16 A So when the TV camera goes in the abdominal cavity is  
17 expanded, so the wall of the abdominal cavity is blown up with  
18 about six liters of carbon dioxide.

19 Q And how is that done?

20 A Through a little pump. There's a little side port on the  
21 main tube.

22 Q So literally like some air or something is pumped and  
23 literally the --

24 A Yeah.

25 Q -- stomach is pushed out.

1 A With a insufflator of carbon dioxide is about six liters.

2 Q Okay. And then the purpose of that is to help you --

3 A It's to move the abdominal wall out of the way and get you  
4 working space.

5 Q Okay. And then after you do that what's -- how does it go?

6 A And two other ports are placed in the left abdomen. They  
7 can either be --

8 Q When you say ports, what do you mean by ports?

9 A Ports are little tubes which you can put your instruments  
10 through.

11 Q Okay.

12 A We have little graspers. We have little scissors. We have  
13 little tools that burn little blood vessels. We can put little  
14 clips on blood vessels through these little ports.

15 Q Okay.

16 A The port in your belly button is about the size of your  
17 thumb. The other ports are about the size of your little  
18 finger.

19 Q Okay. So in terms of -- you can sit down, Doctor. Thank  
20 you. So in terms of actual openings on the patient, you're  
21 talking about just three small openings?

22 A Correct.

23 Q Okay.

24 A Little ports are about a half an inch and the larger port  
25 is an inch at most.

1 Q Okay. And when you do that, what do you do once they're  
2 inside? Like when you're talking TV camera, like how big is  
3 that camera?

4 A Well, the tube is only, you know, the size of your thumb,  
5 but it's projected on a camera this big.

6 Q Oh, a screen?

7 A A screen this big. Correct.

8 Q I see. And once you view -- and the purpose is, I guess,  
9 to view the abdomen.

10 A Correct.

11 Q And to view the appendix, obviously.

12 A Correct.

13 Q And once you do that, what's the next step in that surgery?

14 A The next step is to first locate the appendix and then the  
15 appendix has a couple -- usually one main artery feeding the  
16 blood supply of the appendix, so you need to control that artery  
17 if you're going to take the appendix out. There's a couple of  
18 different ways. You can burn through the artery. You could --

19 Q So when you say burn, what do you mean, burn?

20 A Well, we have a little electrocautery device that we put in  
21 and we just burn the tissues. It just burns where you're  
22 touching. And if you cauterize the artery, it won't bleed.  
23 That's one way.

24 Q I'm sorry. I'm not familiar with these terms, but I don't  
25 think the jury is either. When you say cauterize, what do you

1 mean by cauterize?

2 A Just burn.

3 Q Okay. All right. Continue. Sorry.

4 A And then once you have the appendix, you want to remove the  
5 appendix. You want to take it off at its base.

6 Q Okay.

7 A Where it's coming off of the colon. There is --

8 Q And you would cauterize it at that point? Is that right?

9 A No.

10 Q Okay.

11 A You have to either staple it.

12 Q Okay.

13 A Or you could suture it.

14 Q And how -- you say staple or suture, how is that done? Is  
15 it done just while your instruments are inside the body?

16 A Correct. We have a little stapler that goes through one of  
17 the ports. It has jaws about a little bit more than an inch and  
18 it opens up sort of like an alligator. It goes in. You put the  
19 appendix in the jaws, close it, and then you pull the trigger  
20 and it staples a line of staples that will hold the appendix  
21 closed and cuts it. It staples and cuts at the same time.

22 Q Okay. And then once it's cut what happens to the appendix?

23 A Then we stick in a little bag and we put the appendix in a  
24 little bag and then we bring the appendix out through the belly  
25 button.

1 Q And this is all done inside the person's body?

2 A Yes.

3 Q Okay. And then you're saying that the appendix is then  
4 pulled out of the -- which hole does it pull it out of?

5 A It's pulled out of the belly button because it's a little  
6 bit bigger hole.

7 Q Okay.

8 A It's too big to pull out through the other holes.

9 Q Okay. And then what happens after that, after the appendix  
10 is removed?

11 A Well, we wash out that area and then we close the  
12 incisions.

13 Q Okay. And then how would you close the incisions?

14 A We close them with -- in the umbilicus, we close what's  
15 called the fascia. That's the layer that the muscle is attached  
16 to. We close that with sutures and then we close the skin with  
17 sutures that dissolve.

18 Q Okay. And sutures are what, just like thread?

19 A Yeah. Sutures are the thread we use.

20 Q Okay. And that's -- laparoscopic surgery is also called  
21 keyhole surgery?

22 A Correct.

23 Q Okay. Now, is there another type of surgery that you can  
24 do to remove the appendix?

25 A There's open surgery.

1 Q Okay. What is -- well, what are the benefits of conducting  
2 laparoscopic surgery over an open appendectomy?

3 A Quicker recovery.

4 Q What do you mean by quicker recovery?

5 A Well, with less of an incision size, the patient recovers  
6 quicker.

7 Q What is the likely course of recovery for someone who  
8 undergoes a laparoscopic surgery?

9 A Usually we send them home within one day.

10 Q Within one day after the surgery?

11 A Correct.

12 Q And what kinds of -- would they have any ramifications or  
13 negative outcomes? Do you expect any ramifications or negative  
14 outcomes as a result of laparoscopic surgery?

15 A Depends on the condition of the appendix. If it's an early  
16 appendicitis where the appendix hasn't perforated and there is  
17 no puss within the abdomen, we expect the chance of a post-  
18 operative abscess within the abdomen to be less. If the  
19 appendix is in a more inflamed condition, we would expect a  
20 higher rate of post-operative abscess.

21 Q And do patients who undergo laparoscopic surgery, do you  
22 then continue to treat with them after their surgery?

23 A Yes. We see them in follow up.

24 Q Okay. And for how long do you follow up with them after  
25 that surgery?

1 A Usually, I see them once, two weeks after the operation.  
2 If they're fine, I discharge them from my care.

3 Q Meaning? What do you mean, discharge them from your care?

4 A That I no longer see them on a scheduled basis. I'm always  
5 available if they need me, but I no longer schedule any further  
6 appointments.

7 Q So there's no medical need to see them anymore.

8 A Correct.

9 Q Okay. And what types of -- and in terms of the outcome of  
10 the patient who have undergone a laparoscopy, what can they  
11 expect to feel in terms of either pain or discomfort as a result  
12 of the laparoscopic surgery?

13 A There's some discomfort from the putting the three holes.  
14 It's usually less than an open incision and they can usually  
15 return to work within one to two weeks, depending upon the type  
16 of job they have.

17 Q Okay. Now let's talk a little bit about the open  
18 appendectomy. When would you -- is it a preference to do one  
19 surgery over another, Doctor?

20 A The preference today is to do minimally invasive surgery  
21 for an appendectomy.

22 Q And a minimally invasive surgery would be the laparoscopic.

23 A Correct.

24 Q Okay. And why is that? Why is that the preference,  
25 Doctor?

1 A The patients do better.

2 Q Okay. So let's talk a little bit about the open  
3 appendectomy. Under what -- withdrawn for a second. How many  
4 laparoscopies have you performed?

5 A Hundreds.

6 Q And how many open appendectomies have you performed?

7 A Probably more than 100.

8 Q Okay. And is it your preference to conduct a laparoscopy?

9 A Yes.

10 Q Okay. So when someone presents to you is that your plan,  
11 to initially conduct a laparoscopy?

12 A That would be my procedure of choice.

13 Q Okay. And when would you perform an open appendectomy?

14 A The reasons to perform an open appendectomy would be a very  
15 small child where you thought that the risk benefit ratio --  
16 because you can perform an appendectomy in a four year old  
17 through an incision that's only this big, and so it may be  
18 safer. So if I have a four year old, I may say it's safer to do  
19 an open than laparoscopic.

20 Q And that's because of size of the body?

21 A Size of the body. Or if somebody had extensive surgery  
22 such that you get a patient that had an open gall bladder from  
23 the old days, already had a hysterectomy, already had some other  
24 procedure in the abdomen and has significant scarring that you  
25 don't feel you could safely put in your laparoscopic

1 instruments, then you would perform an open operation. And when  
2 you perform a laparoscopic operation you always have the option  
3 to convert to an open procedure if you think it's indicated.

4 Q I see. Okay. And when would it be indicated, to go from a  
5 laparoscopic surgery to an open appendectomy?

6 A It's indicated when you feel you cannot perform the  
7 laparoscopic surgery safely.

8 Q And you described how a laparoscopic surgery is performed.  
9 Can you describe how an open appendectomy is performed?

10 A First, there's two choices of your incision. In a standard  
11 open appendectomy, we make a small straight incision in the --  
12 over the appendix, which is in the right lower quadrant.

13 Q And when you say incision, how big or large an incision are  
14 you making?

15 A Depends upon the size of the patient.

16 Q Okay.

17 A Generally, it would be under two inches.

18 Q Okay.

19 A And we go down --

20 Q I'm sorry. You said two inches. How does that compare to  
21 the size of the openings or holes that you would make in a  
22 laparoscopic surgery?

23 A Well, the laparoscopic surgery is maybe an inch incision  
24 deep in the belly button and then two other half inch incisions,  
25 but the patient seems to do better than when you do open. They

1 have more pain. When you do it open, once you go through the  
2 skin you then have to separate the muscles. We try not to cut  
3 the muscles going down through the belly. We try to separate  
4 the muscles. And then we get into the abdomen.

5 Q And would you have to -- would you have that issue if you  
6 were doing laparoscopic surgery?

7 A No.

8 Q So you wouldn't have to move the muscles?

9 A No.

10 Q Okay. Is that because you're going already underneath it?

11 A Right. You could just go right through it.

12 Q Through it.

13 A And so it's much better, less chance of hernia. A hernia  
14 is where they separate and it bulges out.

15 Q Sorry. And just to flesh on that a bit more. What are the  
16 ramifications of getting a hernia?

17 A A hernia is where when you make an incision anywhere  
18 through the muscle you sew it closed. It never obtains the  
19 strength that it had originally before it was cut. And as the  
20 time after the surgery, the longer you go after the surgery, you  
21 know, months to years, the tissue thins and it can herniate,  
22 which means it can create a hole in the abdominal wall and then  
23 the intestines can come out of that hole. They don't usually  
24 come through the skin, but you get a lump there. When you  
25 cough, you can feel the intestines and so often you have to go

1 back and repair that hole or defect in the abdominal wall.

2 Q And when you say they come out through the hole, that's --  
3 what do you mean, they come out through the hole?

4 A Well, you have a hole. That's the hernia. And the hernia  
5 itself doesn't give you any problems or a little discomfort.

6 Where you get into trouble with a hernia is that opening in the  
7 abdominal wall, that hole, the small intestine wants to work up  
8 into that hole and the small intestine gets up into the hole and  
9 then it can get caught. It can get trapped. It can get  
10 twisted.

11 Q And if it gets caught, trapped, or twisted, what are the  
12 possible ramifications of that?

13 A Well, you need another surgery.

14 Q So you started to say and I cut you off, regarding the size  
15 of the incision. So you make the incision and then what's the  
16 next thing that happens in an open appendectomy?

17 A In an open appendectomy you find the appendix and then --

18 Q And when you say find it, that's after moving the muscles  
19 around?

20 A Correct.

21 Q Okay.

22 A Once you reach the inside of the abdomen, you locate the  
23 appendix, and at that time we're able to locate the blood  
24 supply. And we do it the old-fashioned way since we can. We  
25 put clamps on it, cut the vessels, and then we just tie them off

1 with --

2 Q As opposed to what you were talking about earlier --

3 A Right.

4 Q -- with inside?

5 A Right. And we don't usually use the stapler when we're  
6 open because we don't need to. We can tie off the base of the  
7 appendix, remove the appendix, and just put some sutures in that  
8 area.

9 Q And when you say tie off, what do you mean?

10 A The appendix is about a tube, your finger, and so before  
11 you cut the base and since there's a hole, there's a lumen in  
12 the appendix. If you just cut the appendix, you know, bowel  
13 movement could pour out of it, so we just put a suture around it  
14 and tie it down so you close it shut, one near the base and one  
15 above it, and then cut between the sutures.

16 Q Okay. And what -- if bowel movement does come out, what  
17 are the possible ramifications of that?

18 A Infection. Bowel movement contains about 80 percent  
19 bacteria, all different kinds of bacteria.

20 Q Okay. So you would clamp it, tie it, and then do you just  
21 literally physically remove the appendix?

22 A Correct.

23 Q Okay. And then once you do that what's the next thing that  
24 happens?

25 A We wash out the area and then we close the incision in

1 layers.

2 Q And when you say wash out, how are we actually washing it  
3 out?

4 A We pour in sterile saline and we have a suction device. So  
5 we just pour it in literally until it's really nice and clean  
6 because sometimes there could be -- if the appendix is advanced  
7 appendix there could be puss, and so we wash it out until the  
8 water is crystal clear and then we aspirate the water and then  
9 we close it in layers.

10 Q Okay. And aspirate just means --

11 A Aspirate just means we suck it out.

12 Q Okay. And the purpose in washing that all out thoroughly  
13 so it's clear is what again, Doctor?

14 A To decrease the chance of a post-operative infection. With  
15 appendicitis, since it's an infective process you always run the  
16 risk of developing an abscess after the operation, so we wash it  
17 out to decrease the risk of developing an abscess.

18 Q And how would you compare the likelihood of getting an  
19 abscess from an open appendectomy as opposed to a laparoscopic?

20 A Laparoscopic appendectomies have a less incidence of  
21 abscesses after the operation.

22 Q Now, Doctor, have you heard of the Alvarado scale?

23 A I have.

24 Q And how have you heard the Alvarado scale?

25 A Through literature and --

1 Q Have you ever used the Alvarado scale in your practice?

2 A No.

3 Q Do you know what the Alvarado scale is? Can you describe  
4 it?

5 A Yes. The Alvarado scale is a scale to take decision points  
6 and assign them a number and try to decide whether the patient  
7 has appendicitis or not. It was popularized in the late 1980s.  
8 The original Alvarado scale was for pregnant women because there  
9 was a -- you didn't want to image. You didn't want to do a CT  
10 scan in a pregnant woman and you're trying to make a best guess  
11 if she would have appendicitis because in pregnancy that can  
12 lift the appendix way out of the abdomen. So a pregnant woman  
13 could present with appendicitis way up under her ribcage,  
14 unlikely that most people would present that way. And it takes  
15 into account some variables.

16 Q And so you mentioned pregnant women. Why would you not  
17 want to conduct imagining on pregnant women?

18 A You could do harm to the fetus.

19 Q Okay. So this scale is used -- so how does this scale, the  
20 Alvarado scale, compare to using imaging?

21 A It's not nearly as accurate.

22 Q Which is more exact?

23 A Imaging.

24 Q Okay. And when you say imagining, what types of imaging  
25 would you expect someone who is experiencing abdominal pain to

1 undergo?

2 A The best type of the CT scan.

3 Q What is a CT scan?

4 A A CT scan is a scan that takes slices through the body like  
5 a loaf of bread and then it recreates them. So we give the  
6 patient a contrast material, so they drink something that is  
7 similar to a chalky milkshake that then allows us to see the  
8 intestines. And then they go through a CT scan. The CT scans  
9 now are very fast. It doesn't take that long at all to scan the  
10 entire abdomen.

11 Q When you say very fast, roughly how long are we talking  
12 about?

13 A Probably two minutes now. They used to be longer. And  
14 then we recreate the scans and it allows us to see inside the  
15 body and actually -- so when we're evaluating the appendix, we  
16 look for the size of the appendix, the size of the wall of the  
17 appendix, is there any fluid around the appendix. They're the  
18 types of information we would get from a CT scan.

19 Q Okay. And how prevalent are CT scans?

20 A Extremely prevalent.

21 Q And I think you said -- and what is involved in sending  
22 someone to get a CT scan?

23 A Well, in the emergency room you just place an order and  
24 then they go over to CT scan.

25 Q Okay. And if you were seeing someone in private practice

1 that didn't come through the emergency room what would be  
2 entailed to send them for a CT scan?

3 A You would call the CT scan, the radiology department, and  
4 say, "I need a CT scan." And they would tell you what available  
5 opening they had for the next available CT scan and then you'd  
6 send the patient for the CT scan.

7 Q And I think you also -- you mentioned that you have treated  
8 inmates.

9 A Yes.

10 Q Okay. If an inmate is in a jail would he be able to get a  
11 CT scan?

12 A He could.

13 Q Okay. And that would be just involving him being  
14 transported to a facility that can conduct a CT scan?

15 A Correct.

16 Q Okay. Can your CT scan also be conducted on site?

17 A No, they're not portable.

18 Q Okay. So somebody would have to -- you'd have to  
19 physically leave a facility to go get a CT scan.

20 A Correct.

21 Q But as you said, the actual time it takes to get a CT scan  
22 is about two minutes for the actual -- for the scan.

23 A Right. It doesn't take that long to actually do the scan.

24 Q Okay. So in terms of timewise from the time I guess  
25 someone goes to get the CT scan until they're finished how much

1 actual time are they in that facility in the process of getting  
2 the CT scan?

3 A Not that long. You know, if you have an appointment and  
4 you come in and they're running on time. It takes a little bit  
5 of time to prep the patient. I mean, the patient needs to have  
6 an IV because they shoot IV contrast in. The patient needs to  
7 have oral contrast. Usually they like to wait an hour after  
8 giving you the oral contrast so that the contrast has enough  
9 time to work its way through the intestines.

10 Q When you say contrast, will you just -- what is the purpose  
11 of the contrast?

12 A The contrast is to show up the intestine because you can  
13 see it on a CT scan, but when you take in a contrast you see --  
14 the intestine lights up and you see it much better.

15 Q I see. Okay. And so from the time of their prep work to  
16 the time they get the CT scan to the time they go back, all  
17 total would that be -- if everybody is on schedule and  
18 everything else, would that be a half an hour or?

19 A It would be more like one to two hours.

20 Q One to two hours. Okay. And, okay. Okay. And is the  
21 Alvarado scale used much today in light of the fact that we have  
22 CT scans?

23 A No.

24 Q And you, in this case, reviewed the medical records from  
25 PrimeCare, which is when Mr. Rodriguez was in the Berks County

1 facility, is that right?

2 A Correct.

3 Q Okay. And did you see any indication that any of the  
4 medical staff or nursing staff used the Alvarado scale?

5 A No.

6 Q Let's go in and talk a little bit about the treatment Mr.  
7 Rodriguez received at the facility.

8 MS. RAMEAU: Your Honor, can we approach briefly?

9 THE COURT: Certainly. Counsel, please approach.

10 (Sidebar)

11 MS. RAMEAU: (Inaudible).

12 MR. NINOSKY: (Inaudible).

13 MR. SALEEM: We could take a longer lunch. I have no  
14 problem with that.

15 THE COURT: (Inaudible).

16 MR. SALEEM: That's fine. Whatever.

17 MR. NINOSKY: (Inaudible) and screw up the case.

18 MR. SALEEM: No, no, no. We have lot, Your Honor,  
19 today pretty much for the doctor. And we've also -- we'll work  
20 with Counsel in terms of the witness (inaudible), so that's  
21 fine.

22 THE COURT: (Inaudible).

23 MS. RAMEAU: Quarter until 1:00? We'll come back at a  
24 quarter until 1:00.

25 THE COURT: (Inaudible).

1 MR. SALEEM: Okay.

2 MS. RAMEAU: Okay.

3 THE COURT: Thank you.

4 (End of Sidebar)

5 THE COURT: Ladies and gentlemen, we are going to  
6 recess for lunch just a little bit early today and we're going  
7 to stand in recess for one hour.

8 Please remember that you are not to discuss the case  
9 among yourselves or with anyone else during the lunch and  
10 recess. Furthermore, you are to wear your juror badges in  
11 obvious place on your clothing while you are in the courthouse.  
12 And you are to avoid reading any newspaper articles or listening  
13 to any media communications regarding this case.

14 You should keep an open mind about this case until all  
15 the evidence is in on both sides, until you've heard the closing  
16 arguments and the charge of the Court, and until you get to the  
17 jury deliberation room because it is only at that time that you  
18 will know enough about this case and about the law to  
19 intelligently and fairly discuss it. So you should refrain from  
20 discussing it with each other or with anyone else, including  
21 members of your family, or allow anyone to talk to you about it.  
22 Do not form any opinions about this case until you retire to the  
23 jury room after my charge.

24 We'll stand in recess for one hour.

25 THE BAILIFF: All rise.

1 (Recess taken at 11:41 a.m.)

2 THE COURT: Continue your direct examination, sir.

3 MR. SALEEM: Great. Thank you.

4 DIRECT EXAMINATION CONTINUED

5 BY MR. SALEEM:

6 Q Doctor, you have the unenviable task of discussing  
7 abdominal pains after we've all had lunch, but we have to  
8 unfortunately get into it. Before we get to the -- just a  
9 matter of housekeeping, Your Honor, I'd like to at this point  
10 move into evidence Plaintiff's Exhibit 1, or sorry, we've  
11 already -- we identified as Plaintiff's Exhibit 1. For the  
12 purpose of this Court, we'll call it Plaintiff's Exhibit 2, Your  
13 Honor, which are the PrimeCare medical records which are Bate  
14 stamped numbered 1 through 516.

15 THE COURT: Mr. Ninosky, any objection to the  
16 admission of Plaintiff's Exhibit 2, which are the medical  
17 records?

18 MR. NINOSKY: No, Your Honor.

19 MR. SALEEM: And --

20 THE COURT: Without objection, Plaintiff's Exhibit 2  
21 is admitted into evidence.

22 (Plaintiff's Exhibit 2 admitted)

23 MR. SALEEM: Thank you, Your Honor.

24 And also while we're doing that, I'd like to move into  
25 evidence identified as Plaintiff's Exhibit 2, but for the

1 purpose of this Court, move into evidence as Plaintiff's Exhibit  
2 3, which are the Reading Hospital medical records which are Bate  
3 stamped Berks' 1489 through 1625.

4 THE COURT: Mr. Ninosky, any objection to Plaintiff's  
5 Exhibit 3?

6 MR. NINOSKY: No objection, Your Honor.

7 THE COURT: Without objection, Plaintiff's Exhibit 3  
8 is admitted into evidence.

9 (Plaintiff's Exhibit 3 admitted)

10 MR. SALEEM: Great. Thank you, Your Honor.

11 And finally, at this point I'd like to introduce into  
12 evidence Berks' 645 through 649. That is the --

13 MR. NINOSKY: No objection, Your Honor.

14 THE COURT: And what is Plaintiff's Exhibit 4?

15 MR. SALEEM: And that is the surgical pathology  
16 report, Your Honor, that was taken on April 20th.

17 THE COURT: Very well. Without objection, Plaintiff's  
18 Exhibit 4 is also admitted to evidence.

19 (Plaintiff's Exhibit 4 admitted)

20 MR. SALEEM: Great. Thank you, Your Honor.

21 THE COURT: You're welcome, sir.

22 BY MR. SALEEM:

23 Q Okay. Doctor, before we get into the records, you had  
24 mentioned before we broke for lunch that you have treated  
25 inmates as part of your practice, is that right?

1 A That's correct.

2 Q Okay. Does your treatment of a patient differ in any way  
3 if you knew they were an inmate?

4 A No.

5 Q Okay. So there's no modified standard of care for inmates  
6 as opposed to people who have not been -- not an inmate?

7 A Correct.

8 Q Okay. And the human body that's situated in a jail is the  
9 same as a human body that's outside a jail?

10 A Yes.

11 Q Okay. So would you expect there to be any kind of modified  
12 standard of care just because someone is an inmate?

13 A There should be none.

14 Q Okay. All right. And in your practice, Doctor, what type  
15 of -- do you supervise other types of medical staff or other  
16 doctors?

17 A Yes.

18 Q And what titles or roles do they have?

19 A Residents.

20 Q Okay. Do you also supervise interns?

21 A Yes.

22 Q Okay. So interns would be the first year out of medical  
23 school?

24 A Correct.

25 Q And then residents could be second, third, fourth year out

1 of medical school?

2 A Correct.

3 Q Okay. Do you also have fellows underneath you at all?

4 A Not at this time.

5 Q Okay. And do you also have part of your team, any nurses?

6 A I've had physician assistants.

7 Q Physician assistants, okay. And do the interns who are  
8 underneath you conduct history and physical of patients?

9 A Yes.

10 Q Okay. And does the supervisor of them review their work?

11 A Yes.

12 Q Okay. And so just the process of conducting history and  
13 physical would be the doctor, in this case, an internist would  
14 be the first year out of medical school --

15 A Correct.

16 Q -- would go and actually see the patient and examine them,  
17 right?

18 A Correct.

19 Q And then they would document that in the chart?

20 A Yes.

21 Q Okay. And would you rely upon that examination or would  
22 you conduct your own examination?

23 A No, I would conduct my own exam.

24 Q Okay. And what is the purpose of also conducting your  
25 examination if they've already seen the patient?

1 A To verify that they've correctly performed the assessment.

2 Q Okay. And it's fair to say that you have more experience  
3 in terms of conducting an exam than a first year medical  
4 student?

5 A Yes.

6 Q First year resident, at least?

7 A Right.

8 Q Okay. Okay. And I just touched upon the term, the chart.  
9 What is the medical chart?

10 A The medical chart is the record of everything that goes on  
11 during the medical experience of the patient.

12 Q Okay. And what is its purpose? What is its purpose for  
13 you as a doctor?

14 A Its purpose to communicate to everybody that is taking care  
15 of the patient. It's a home for all the information we're  
16 gathering. And it serves as a record in the future of what went  
17 on in the past.

18 Q Okay. And do you rely upon the medical record?

19 A Yes.

20 Q Okay. And do you rely -- and do you make entries in the  
21 medical record?

22 A Yes.

23 Q Okay. And do other people also look at the medical record?

24 A Yes.

25 Q Okay. And the medical chart.

1 A Yes.

2 Q So is it fair to say that it's important when you're making  
3 entries to be accurate?

4 A Correct.

5 Q Okay. It's important to be precise.

6 A Correct.

7 Q Okay. And the purpose is because other people are making  
8 medical decisions based upon what's come before.

9 A Correct.

10 Q Okay. Doctor, I'm not going to go through all 516 pages of  
11 the medical records from at least the PrimeCare. I just want to  
12 highlight certain pages and I'll just refer to them by Bates  
13 number when I go through. Let me -- and I'm going to put them  
14 on the -- since they're in evidence, I'm just going to put them  
15 on the ELMO machine so you don't have to get up or anything.

16 A Thank you.

17 Q Now, I'm just going to first direct your attention. I  
18 believe they're the first -- and you've reviewed these before,  
19 right, Doctor?

20 A Yes.

21 Q Okay. So I think the first instance of, at least that's  
22 documented, of Mr. Rodriguez complaining of medical pain that's  
23 in the chart at least occurred on April 16th. Would you agree?  
24 Do you have any reason to disagree with that?

25 A No.

1 Q Okay. Okay. Put this on the -- the writing is very small,  
2 but I'm going to try to make it bigger. I'm looking right now  
3 for the record at PCM60. Too fast. Let me know, Doctor, when  
4 you think it's --

5 A Okay. That's fine.

6 Q -- clear enough to you and, Your Honor, is it clear enough  
7 to Your Honor or -- I just want to make sure that the jury can  
8 also be able to see it. Okay. So just based upon this chart,  
9 it appears that this was documented on April 16, 2015, is that  
10 fair?

11 A Correct.

12 Q Okay. And this section of the chart is called what, an  
13 abdominal complaints chart, is that right?

14 A Yes.

15 Q Okay. And in this case it appears -- when it says  
16 interviewer, does that appear as if the person who conducted  
17 this assessment?

18 A Yes, I would assume.

19 Q Okay. And in this case that would be Susan Roberts.

20 A Yes.

21 Q Okay. An LPN, what is an LPN?

22 A A licensed practical nurse.

23 Q Okay. Do you know how much schooling they have?

24 A Usually less than 18 months.

25 Q Okay. And in this case, okay. And what is the chief

1 complaint that is listed right here, the first line?

2 A Stomach pains times two days.

3 Q If you can't read it -- there we go. Okay. And by times  
4 two days, what does that indicate to you?

5 A That it's been going on for 48 hours.

6 Q Okay. So if this note was made on April 16, 2015, when  
7 would your review of the chart, when would you believe that the  
8 pain is -- the person who wrote this chart is indicating that  
9 the pain started?

10 A April 14th.

11 Q Okay.

12 A Or the 15th.

13 Q Fourteenth or the fifteenth, okay. And then this is --  
14 okay. So, and what is this -- when it says, "Not relieved by  
15 Maalox," to you what does the significance of that mean?

16 A That means that the patient took Maalox and still had the  
17 pain after he took Maalox.

18 Q Okay. So you would expect to see, if there's a section of  
19 the chart that has the medical administration record, you would  
20 expect to see some indication that he was being given Maalox.

21 A Correct. That the Maalox was given, what time it was  
22 given, and how much Maalox was given.

23 Q Okay. And what is Maalox? Like what's Maalox?

24 A Maalox is an antacid.

25 Q Okay.

1 A It basically absorbs the acid in your stomach and coats the  
2 lining of your esophagus and stomach.

3 Q Okay. And what's the purpose of it?

4 A To decrease heartburn.

5 Q Okay. And the next line says, "Recently started Naproxen  
6 375 mg BID." First off, what does BID stand for?

7 A BID is twice a day.

8 Q Okay. And 375 mg, that's just the dosage that was given?

9 A Correct.

10 Q That's 375 mg twice a day?

11 A Correct.

12 Q Okay. And what is Naproxen?

13 A Naproxen is a non-steroidal anti-inflammatory medication,  
14 very much similar to Motrin or Advil.

15 Q Okay. And what significance, if any, is there, the fact  
16 that the patient had recently started Naproxen and now is  
17 experiencing stomach pain?

18 A One of the side effects of medicines such as Naproxen is  
19 irritation of the stomach.

20 Q Okay. And now underneath that section, the section that  
21 says, "If pain is present, describe it," and there's three  
22 categories. You see that dull, sharp cramping?

23 A Correct.

24 Q What is the significance of the fact that it's checked off  
25 "sharp and cramping"?

1 A They're very non-specific.

2 Q Okay. Does that mean anything to you in terms of an exam,  
3 that the patient's just on its face just sharp and cramping as  
4 opposed to dull?

5 A Cramping is usually more severe than dull and sharp is  
6 usually localized because it's sharp like somebody is stabbing  
7 you with a knife. It's a sharp more localized pain. Cramping  
8 is not so localized. That would be over most of the abdomen.  
9 You usually can't localize cramping.

10 Q Okay.

11 A And dull is a mile discomfort.

12 Q Okay. And when you examine a patient, are you looking to  
13 see if the pain is dull, sharp cramping or are you looking at  
14 different metrics?

15 A No. I use the same metrics pretty much.

16 Q Okay. And the next section talks about intensity of pain.  
17 What is the intensity of pain? How is that asked?

18 A Well, in the hospital we use a scale of one to ten, with  
19 ten being the worst pain of your life, one being very minimal  
20 notice of any pain, and we ask the patient to give us a number.  
21 We also have a chart that is a non-verbal chart. It shows a  
22 smiley face and you can see where the patient is smiling, which  
23 is no pain, happy, and then where they go with a blunted  
24 expression to where they look like they're in a lot of pain to a  
25 ten where the patient looks severely in pain.

1 Q And what is the purpose of using the smiley faces when  
2 you're trying to ascertain a patient's pain level?

3 MR. NINOSKY: Objection. Outside the scope. There's  
4 nothing in his report concerning this.

5 THE COURT: Counsel, please approach.

6 (Sidebar)

7 MR. NINOSKY: There's no discussion about any sort of  
8 smiley faces or anything else in the report that was authored.  
9 There's also no such document in the Reading records that either  
10 he authored or anybody else's record.

11 MR. SALEEM: And just (inaudible).

12 MR. NINOSKY: Well, that I agree with, but the flip  
13 side of it is how he conducts his examination, it isn't relevant  
14 if he's using smiley faces or not. What's relevant is whether  
15 there was an evaluation that was done with this particular  
16 patient.

17 MR. SALEEM: (Inaudible).

18 THE COURT: (Inaudible).

19 (End of Sidebar)

20 MR. SALEEM: And --

21 THE COURT: And, Mr. Saleem, you may proceed, sir.

22 MR. SALEEM: Thank you, Your Honor.

23 BY MR. SALEEM:

24 Q And what is the purpose of using the smiley face as opposed  
25 to actually asking the patient to describe the pain, the

1 severity of pain?

2 A It's another means of helping the patient pinpoint exactly  
3 what their pain is.

4 Q And this is done for all patients? You are given the  
5 smiley level chart for all patients?

6 A No. Some patients are patients that can give you a number.  
7 Some patients of areas give you a number. Some patients  
8 struggle with the number concept.

9 Q Okay.

10 A And the smiley faces help them.

11 Q Okay. And in this case the fact that it was noted that the  
12 intensity of pain was moderate, what, if anything, significance  
13 does that have to you?

14 A That it was more than just uncomfortable, that it was  
15 getting to be, you know, very uncomfortable.

16 Q Okay. Are terms moderate and severe something that you  
17 would use in your assessment of a patient?

18 A I might.

19 Q Okay. And what is this next line, the significance of the  
20 fact that it says pain -- what makes pain worse? That it  
21 increases with medication. What is that, if anything, of  
22 significance to you?

23 A Really not much.

24 Q Okay. Now when it says increases of the medication, we  
25 just discussed the patient was getting two different types of

1 medication. From that entry, can you tell if it's pain  
2 increases with the medication of the Naproxen or pain increases  
3 with Maalox?

4 A You can't tell.

5 Q Okay. So this is an entry that's not clear to you. It's  
6 not clear in the chart.

7 A Correct.

8 Q Okay. And would it make a difference to you as in terms of  
9 your diagnosis or your treatment of the patient which medication  
10 is causing him pain?

11 A It may.

12 Q Okay. And the next entries indicate that the patient was  
13 nauseous. And just for purposes, just so we're all clear, what  
14 does nausea mean?

15 A Nausea is unsettled stomach.

16 Q Okay. And in this case, vomiting, it was checked off that  
17 he was not vomiting, is that right?

18 A Correct.

19 Q Okay. And what about BM? What does BM stand for?

20 A Having a bowel movement.

21 Q Okay. All right. And in this case, it was noted as normal  
22 and his urination is also noted as normal.

23 A Correct.

24 Q Okay. Next says vital signs were taken. Of what  
25 significance do you note anything regarding his vital signs?

1 A They appear to be normal.

2 Q Okay. And, okay. And it says in general appearance --  
3 what do you make of the fact that it says, "Looks to be in  
4 pain?" What significance does that present to you with someone  
5 who is already experiencing the same symptoms that we just  
6 finished talking to you about?

7 A It correlates that he's having, you know, being  
8 uncomfortable, that he's in pain.

9 Q Okay. And what significance, if any, is the fact that  
10 there are bowel sounds active. What does that mean?

11 A Bowel sounds are normally active within the abdomen and  
12 some conditions can cause the intestines to shut down.

13 Q Okay.

14 A Severe inflammation within the abdomen.

15 Q And how are you determining that bowel sounds are active?  
16 How are you noting that?

17 A We use a stethoscope to make that assessment.

18 Q Okay. And if bowel sounds -- so a normal finding, would we  
19 expect to hear the sounds when you're listening to the abdomen,  
20 is that right?

21 A Correct. And there can be a character, the sounds. They  
22 can be diminished. They can be high pitched.

23 Q Okay. And is that something that you have been trained to  
24 listen to?

25 A Correct. Yes.

1 Q Okay. And if they are absent, what, if anything, for  
2 significance could that mean?

3 A That could mean that there's some process going on within  
4 the abdomen.

5 Q Okay. And just the last line on there, it says soft.  
6 What, if anything, is significant of the fact that it's noted --  
7 I think it's continued, sorry -- from the next page just so  
8 you're clear. Looking at 60 and 61 right now, PCM.

9 A Okay.

10 Q So would palpation mean touching?

11 A Yes.

12 Q Okay. So touching the abdomen reveals that it's I think  
13 soft and tender. What, if any, significance does that have to  
14 you?

15 A Well, soft as opposed to rigid. As the patient develops a  
16 rigid abdomen it's harder like a board. Soft is more like a  
17 pillow, which is normal. Softness would be a normal quality of  
18 the abdomen. And tenderness is an abnormal quality of the  
19 abdomen. Generally, when you examine the abdomen it shouldn't  
20 be tender.

21 Q Okay. And what, if any, effect does it have depending on  
22 the size of the patient or the size of their abdomen in terms of  
23 assessing whether it's soft or not?

24 A Well, in larger patients it can be difficult to pick up  
25 rigidity in the abdomen. So the abdomen can generally be softer

1 in patients that have a higher body mass index, but tenderness  
2 would be the same.

3 Q Okay. And in terms of this case, if Mr. Rodriguez was  
4 5'11" and his weight ranged in the range of around 280 pounds,  
5 medically speaking how would you characterize him?

6 A He has an increased body mass index.

7 Q Okay. And would he be, medically speaking, be considered  
8 obese?

9 A Yes.

10 Q Would he be considered morbidly obese? Is that a higher  
11 level of obesity or no?

12 A No. Just moderate obesity.

13 Q Just obese. Okay. And there are other terms here in terms  
14 of under palpation. What is rebound tenderness?

15 A Rebound tenderness is when you push on one side of the  
16 abdomen and then you release it and you get -- the pain rebounds  
17 to the other side.

18 Q Can you just demonstrate to the --

19 A Yeah. So when you examine the patient with appendicitis,  
20 the appendix is usually located on the right lower quadrant.  
21 You push in the left side and then when you release it is when  
22 the patient gets the pain.

23 Q On the other side?

24 A On the other side.

25 Q I see. Okay. And what about the term guarding, which is

1 also noted there?

2 A Guarding is when the patient's abdomen is rigid and so when  
3 you feel the abdomen it's tense more like a board and the  
4 patient will tense up their abdomen because they don't want you  
5 to push on their abdomen because it hurts.

6 Q I see. Okay.

7 A So they essentially guard their abdomen. That's where the  
8 term comes from.

9 Q I see. Okay. And now the next section talks about the  
10 location and description of findings. LUQ, does that stand for  
11 lower -- I mean, left upper quadrant?

12 A Left upper quadrant.

13 Q LLQ is left lower quadrant?

14 A Correct.

15 Q And RUQ is right upper quadrant --

16 A Correct.

17 Q -- and right lower quadrant.

18 A Correct.

19 Q So just a reminder is these are the quadrants we were  
20 talking about earlier.

21 A Correct.

22 Q So what, if any, significance is it to you that the patient  
23 is presenting with pain that is in the left upper quadrant and  
24 right upper quadrant?

25 A They're non-specific findings.

1 Q Okay. And what about the fact that -- now, once you  
2 conduct the -- now, in terms of your examination when someone  
3 presented to you with abdominal pain, I think we talked about  
4 the history, right? You would conduct that.

5 A Correct.

6 Q And then the next thing would be the physical, right?

7 A Correct. The physical.

8 Q Is there something that you use in terms of when you're  
9 conducting an examination called SOAP, an acronym?

10 A SOAP is a way we record an assessment.

11 Q Okay.

12 A So when you have a patient who presents for the first time  
13 you do what's called a history and physical examination where  
14 you take the history of the illness, you perform a physical  
15 examination, and then you formulate a differential diagnosis,  
16 which is an assessment, and then you formulate a plan based on  
17 that differential diagnosis. When we do follow up or daily  
18 assessments of the patient, we use the acronym SOAP, S-O-A-P.

19 S is subjective. How are you feeling? How are things  
20 going? How are you eating? You know, is anything going on?  
21 Object, for object of signs such as vital signs, such as your  
22 physical examination, you know, heart, lungs, abdomen, skin.  
23 And then A is your assessment. Is the patient getting better?  
24 Is the patient getting worse? And P is your plan. You know,  
25 are we going to stay the course? Are we going to change the

1 course?

2 Q Okay. And based upon what has been presented to you right  
3 now based on what we just reviewed, what would your assessment  
4 be at this point?

5 A My assessment would be that the patient's getting worse  
6 since he's stating he's had pain for 48 hours or 2 days and that  
7 it was not relieved by Maalox he was recently on and he's now  
8 exhibiting abdominal tenderness.

9 Q All right. And in your mind, what would you be suspecting  
10 is the cause of that abdominal tenderness?

11 A Well, I would have a differential diagnosis of acute  
12 appendicitis, gastritis, a viral gastroenteritis would be three  
13 of the most common abdominal complaints.

14 Q Okay. And why are you suspecting acute appendicitis at  
15 this point?

16 A Acute appendicitis is one of the most common complaints  
17 within the abdomen of abdominal pains within the abdomen of  
18 abdominal pain, especially in age group from 15 to 25 or  
19 certainly from 10 to 30, common in males because in women you  
20 have more differential diagnosis. Ovarian cists, twisted ovary,  
21 tubal pregnancy, a lot more common. Urinary tract infections in  
22 women. So that in men the differential diagnosis is slightly  
23 narrow than women.

24 Q And at the time this was conducted how old was Mr.  
25 Rodriguez?

1 A Twenty-two.

2 Q Okay. So because -- and because you had several different  
3 differential diagnosis, would that effect the -- that was your  
4 assessment? Is that the (inaudible)?

5 A Yes.

6 Q Okay. And would that then lead you to determine what your  
7 plan is?

8 A Correct.

9 Q Okay. Now, so acute appendicitis, is that fair to say that  
10 that's the most severe of your potential differential diagnosis  
11 of the ones that you're factoring into?

12 A Yes. Yes.

13 Q Okay. So, and I think of the ones you mentioned would  
14 gastritis be on the lower end?

15 A Yes.

16 Q Okay. And is gastritis also referred to as stomach upset  
17 or GI upset?

18 A Yes.

19 Q Okay. So would your treatment -- and is there any danger  
20 to the patient if you only consider one of those differential  
21 diagnosis? Say the lowest one, as opposed to the higher one?

22 A Yes.

23 Q What could --

24 A Because you could miss the diagnosis.

25 Q Okay. So if you're talking about that funnel earlier, you

1 want to keep that funnel wide open to think of multiple possible  
2 avenues.

3 A Correct.

4 Q Since you don't want to turn the funnel on its head and  
5 just focus on one, correct?

6 A Correct.

7 Q Okay. So in this case, what was the assessment that was  
8 noted in the chart here?

9 A GI upset.

10 Q Okay. And were there any other differential diagnosis or  
11 upsets noted in the chart?

12 A No.

13 Q Okay. And of what significance to you is the fact that  
14 only GI upset was noted as a possible type of pain, cause for  
15 the type of pain?

16 A That other diagnosis may not have been considered.

17 Q Okay. And is the danger in not considering the other  
18 diagnosis is that -- what is the danger in just focusing on one  
19 diagnosis to the exclusion of the others?

20 A You can't make a diagnosis if you don't think about it.

21 Q All right. And in this case, so because the assessment was  
22 considered GI upset is it fair to say then that the plan  
23 followed that assessment?

24 A Correct.

25 Q Okay. And because the assessment was not looking at your

1 other differential diagnosis like appendicitis the plan was not  
2 focusing on treating appendicitis, is that fair to say?

3 A Correct.

4 Q Okay. And in this case does it indicate -- is that  
5 consistent with what is documented in the plan as to what the  
6 course of treatment was for the Plaintiff, Mr. Rodriguez?

7 A Yes. He would report worsening symptoms, increase oral  
8 fluids.

9 Q And what in terms of medication was provided to him?

10 A Pepto Bismol and Maalox.

11 Q Okay. And Pepto Bismol and Maalox, are those medications  
12 that are meant to treat GI upset?

13 A Yes.

14 Q Would you, if you're suspecting a patient who has  
15 appendicitis, would you expect to give them Maalox and Pepto  
16 Bismol?

17 A No.

18 Q Okay. And why not?

19 A Well, they're not effective and if I thought the patient  
20 had appendicitis I wouldn't feed the patient.

21 Q What do you mean, you won't feed the patient?

22 A Well, because patients that have appendicitis, you know,  
23 often need surgery. If I didn't think that they or it was very  
24 early in on the course, you could give Maalox or Pepto Bismol.  
25 There's not much of a down side to that. Although he already

1 had Maalox and it hadn't been effective. You know, I don't know  
2 that I would add Maalox and Pepto Bismol together. You know, I  
3 would do one or the other, but there's not much downside to  
4 either of them.

5 Q And when you say -- so is the failure to consider other  
6 differential diagnosis with someone presenting with the symptoms  
7 that Mr. Rodriguez presented a deviation from the standard of  
8 care?

9 A Well, you have an LPN making an assessment and a diagnosis  
10 which is beyond the scope of practice for an LPN. So an LPN can  
11 collect information and then needs to provide that information  
12 to a higher level practitioner to actually even formulate the  
13 diagnosis and to make a plan.

14 Q Okay.

15 A So --

16 Q Sorry. I didn't mean to cut you off.

17 A So I don't see that the LPN, you know, they can collect  
18 information, but they have to then give the information to  
19 somebody else to make a diagnosis or a plan.

20 Q And can an LPN prescribe medication or would it have to go  
21 through either a nurse practitioner or a doctor to get it  
22 through that?

23 A It would have to go through a higher level practitioner.

24 Q So the fact that the -- and there's indication in the plan  
25 that there was medication prescribed, does that indicate to you

1 that this nurse, Ms. Roberts, had already spoken to some sort of  
2 provider level?

3 A I would assume so.

4 Q Okay. And what is the -- in terms of the referral, what  
5 does it indicate in the referral there, the second to last box?

6 A That the patient would initiate a follow up visit if the  
7 patient thought he wasn't improving.

8 Q Okay. And what's PRN mean?

9 A As needed.

10 Q Okay. So that's based upon as needed, the patient making  
11 that own determination?

12 A Correct.

13 Q Okay. And what, if anything, is significant about the last  
14 line, education?

15 A Report worsening symptoms and increase fluids. Worsening  
16 symptom is something that the patient feels, nausea, fever,  
17 vomiting, or pain.

18 Q Okay. And what is the significance about increasing the  
19 fluids?

20 A That would be to increase your oral fluid intake.

21 Q And how would that -- someone who's presenting with  
22 symptoms of appendicitis, what, if any, effect would that have?

23 A Well, usually with appendicitis once you start the  
24 abdominal pain the nausea and the vomiting come after the  
25 abdominal pain. And so patients that are developing

1    appendicitis often go on to then develop what we call anorexia  
2    or they lose their appetite. And then they don't want to eat  
3    and they don't want to drink because it hurts their abdomen and  
4    they tend not to eat or drink.

5    Q     So just to be clear, the term anorexia, I mean, it's not  
6    the way we use it in popular culture.

7    A     Right.

8    Q     But medically speaking, it just means loss of appetite?

9    A     Loss of appetite.

10   Q     Okay. And when you are -- so under this circumstance if  
11   you were presented by an LPN who conducted this sort of  
12   assessment what would your plan be at this point?

13   A     My plan would to then see the patient and perform my own  
14   assessment.

15   Q     And why would you want to see the patient at this point?

16   A     Well, the patient is becoming ill and the patient has  
17   sufficient complaints to warrant an evaluation. He's having  
18   abdominal tenderness. It didn't respond to Maalox. I would  
19   want to perform my assessment to see if I thought that he had a  
20   mild abdominal complaint or if it was something more serious.

21   Q     And you being you, being a doctor, want to physically lay  
22   hands and lay eyes on a person, is that correct?

23   A     Correct.

24   Q     Okay. And would that be a deviation of someone who was  
25   presenting with these symptoms, these complaints, to not be seen

1 by either a medical care provider on the level of either a nurse  
2 practitioner, physician's assistant, or a doctor?

3 A It would be if he eventually was not seen at some point.

4 Q Okay. So you would expect as a result of this at some  
5 point to see the patient?

6 A Especially if symptoms persisted.

7 Q Okay. And when you say at some point, how soon after, if  
8 the patient is presenting with these symptoms and there's  
9 documentation that his symptoms did not go away, how soon after  
10 this assessment would you expect to lay hands and lay eyes on  
11 the patient?

12 MR. NINOSKY: Objection. Outside the scope.

13 THE COURT: Response?

14 MR. SALEEM: I think it's directly in line with what  
15 he was talking about.

16 THE COURT: Counsel, please approach.

17 (Sidebar)

18 MR. NINOSKY: There's nothing in his report talking  
19 about the timeliness other than obviously there's no diagnosis.  
20 There's no anything in his report saying that all the  
21 (inaudible) in this report had to have been this particular  
22 person. Would have had to have seen this patient sooner, which  
23 he wasn't in the facility. There's nothing in there about that.

24 MS. RAMEAU: But he did talk in his report about a  
25 timely diagnosis and this is a late diagnosis, so it's

1 (inaudible).

2 THE COURT: (Inaudible).

3 MR. SALEEM: (Inaudible). Obviously it comes into  
4 play because (inaudible).

5 MR. NINOSKY: Well, there's nothing in his report  
6 about Paula Dillman having either come into the facility or  
7 timeliness of her doing an exam. That's different. There are  
8 several days in there and that's their theory of the case. He's  
9 going to be able to say that it should have been diagnosed  
10 quicker. I get that, but this is a specific question trying to  
11 establish a standard of care for time as to when Paula Dillman  
12 should have done an exam. That's not in the report.

13 THE COURT: I'll sustain the objection. (Inaudible).

14 (End of Sidebar)

15 Mr. Saleem, you may proceed, sir.

16 MR. SALEEM: Thank you, Your Honor.

17 BY MR. SALEEM:

18 Q Doctor, I'm now going to show you -- what we just looked at  
19 was the assessment that was done by Ms. Roberts. I'm going to  
20 show you now Plaintiff's 2, Bates stamped PCM202. And, Doctor,  
21 this document was written by Ms. Roberts again, is that right?

22 A Yes.

23 Q Okay. And it was also on April 16, 2015, is that right?

24 A Correct.

25 Q Okay. And this document is a telephone order form to --

1 meaning that who did she speak to in this document where it says  
2 provider giving the orders?

3 A I don't know.

4 Q Do you see that?

5 A Where?

6 Q It's about right over here.

7 A Oh, P. Dillman-McGowan.

8 Q Okay. And what does CRNP stand for?

9 A Certified Nurse Practitioner.

10 Q Okay. So in this case Ms. McGowan was the -- and case  
11 nurse practitioners give orders?

12 A Yes, they can.

13 Q Okay. And this leads you to believe this is a follow up  
14 documentation after Ms. Roberts' assessment that we just talked  
15 about a second ago?

16 A Yes.

17 Q Okay. And this is documentation of her conversation with  
18 Ms. McGowan.

19 A Correct.

20 Q Ms. Dillon-McGowan, okay. And in addition, reason provider  
21 called. And in that indication, is that an indication of what  
22 Ms. Roberts is conveying to Ms. Dillon-McGowan?

23 A Correct.

24 Q Okay. And does it indicate that this is something that's  
25 done -- this is a telephone or verbal order form, right?

1 A Correct.

2 Q Okay. And see where it says patient described as tearing  
3 in quotes, tearing or T-E-A-R-I-N-G, which --

4 A Yes.

5 Q Okay. That could be pronounced tearing like with eyes or  
6 tearing with ripping, right?

7 A I would think crying, tearing up.

8 Q Okay. Okay. But it's not -- again, it's not clear, right?

9 A Correct.

10 Q You were making that assumption.

11 A Correct.

12 Q Okay. If a patient makes a statement that's -- what is the  
13 purpose of putting a statement in quotes?

14 A In quotes, it usually -- usually we put it in quotes if  
15 it's coming from -- if the patient said something.

16 Q Okay.

17 A You know, then we put it in quotes. That's a description.  
18 You know, the patient wouldn't say, "I'm tearing."

19 Q Okay.

20 A You know, so I'm not sure why it's in quotes.

21 Q Okay. But could it also be tearing in the sense that the  
22 pain feels like it's tearing?

23 MR. NINOSKY: Objection. It's speculation at this  
24 point.

25 MR. SALEEM: Well, he just mentioned this. I'm just

1 trying to clarify what's --

2 THE COURT: I assume Mr. Rodriguez will be able to  
3 testify as to what -- well, maybe I shouldn't assume that. But  
4 whatever was said and whatever it meant, I don't think it's  
5 appropriate to try to speculate on that.

6 MR. SALEEM: Well --

7 MR. NINOSKY: And we know that Nurse Roberts is going  
8 to say what it meant because she is the one who made the  
9 documentation.

10 MR. SALEEM: What I am just trying to get at, Your  
11 Honor, is just my whole point is that it's not clear based upon  
12 the document. There's two possible meanings.

13 THE COURT: Very well.

14 BY MR. SALEEM:

15 Q Is that fair to say, Doctor?

16 A Yes.

17 Q Okay. And I think we discussed earlier the importance of  
18 making documents in the medical chart is to be clear, right?

19 A Correct.

20 Q And you want to be precise because other people are looking  
21 at it.

22 A Correct.

23 Q Right. And in this case you don't know if it's tearing  
24 with eyes or tearing as in a stripping, a shredding sort of.

25 MR. NINOSKY: Objection, as to leading.

1 MR. SALEEM: Okay. That's fine. I'll withdraw that.

2 THE COURT: The objection is sustained.

3 BY MR. SALEEM:

4 Q That's fine. And it also notes complains of acid reflux.

5 Do you see that?

6 A Yes.

7 Q C slash O, does that mean complains of?

8 A Yes.

9 Q Okay. Do you know -- we previously looked at other  
10 documents. Did it make any mention of acid reflux in that and  
11 under the chief complaints?

12 A I think it's on the other page. No.

13 Q Can I approach, Your Honor?

14 THE COURT: Certainly. That's fine.

15 BY MR. SALEEM:

16 Q Okay. I just want to know if you see a mention of acid  
17 reflux.

18 A Yeah, the heartburn is not checked.

19 Q Heartburn is not checked?

20 A Not checked.

21 Q Okay. And would expect heartburn to be checked if someone  
22 is complaining of acid reflux?

23 A Right. I would assume they're essentially synonymous  
24 terms.

25 Q Okay. And would someone, a patient in this case,

1 necessarily use the term acid reflux?

2 A No.

3 Q Okay. That's something that more the medical personnel  
4 use?

5 A Correct.

6 Q Okay. So the fact that it's indicated that the patient is  
7 describing as tearing and also complains of acid reflux, does  
8 that mean that in this case Ms. Roberts is making an assessment  
9 that she thinks Plaintiff has acid reflux as opposed to him  
10 actually saying, "I have acid reflux?"

11 MR. NINOSKY: Objection. Speculation.

12 THE COURT: Counsel, please approach.

13 (Sidebar from 1:37 p.m. to 1:46 p.m.)

14 THE COURT: And, ladies and gentlemen, whenever we do  
15 have a bench conference, we try to keep them to a minimum, but  
16 feel free to stand up and stretch if you wish to. You don't  
17 have to remain seated during those conference.

18 Mr. Saleem, you may continue, sir.

19 BY MR. SALEEM:

20 Q Great. Thank you, Your Honor. And as a result of this  
21 phone conversation with Ms. McGowan, what orders did she give in  
22 respect to medication?

23 A To discontinue the Naproxen.

24 Q That's -- DC means discontinue?

25 A Yes.

1 Q Okay.

2 A Stop taking.

3 Q Okay. And what was the purpose of discontinue -- what  
4 would be the purpose of discontinuing the Naproxen?

5 A It may be contributing to abdominal discomfort.

6 Q Okay. And it appears that three different types of  
7 medication were prescribed?

8 A Yes.

9 Q Okay. Including the Maalox that had previously been given  
10 to him?

11 A Yes.

12 Q Okay. Okay. So that was -- that entry was made around  
13 September -- April 16th around 9:32, 21:32 is 9:32.

14 A Correct.

15 Q Okay. And the next entry I'm looking at is PCM73. Under  
16 this indication, I just want to focus your attention on the  
17 middle note with 41715. And in this case, the note is that his  
18 -- this is authored by Allison Young. She's an RN. Is that  
19 fair?

20 A Correct.

21 Q But it indicates that she would assess by -- appears to be  
22 assessed by another individual, is that fair?

23 A Patient assessed on K unit by Tracy Reeves.

24 Q Okay. So you would expect there to be some indication of  
25 Ms. Reeves assessing the patient in the chart, right?

1 MR. NINOSKY: Object again, Your Honor.

2 MR. SALEEM: I'll withdraw that.

3 THE COURT: Okay.

4 BY MR. SALEEM:

5 Q There were vital signs taken, both blood pressure and heart  
6 rate?

7 A Correct.

8 Q Okay. And it says that patient states he's still vomiting.  
9 What, if any, significance do you place on that?

10 A That he was already vomiting.

11 Q Okay. And when we looked at the chart earlier the  
12 indication from Ms. Roberts, what did she note as to whether or  
13 not Mr. Rodriguez was vomiting?

14 A That he wasn't vomiting.

15 Q So but now a chart note has mentioned that he is vomiting  
16 later, so --

17 A Correct.

18 Q Okay. And at this time as a result of him vomiting it  
19 appears that -- it says a provider was called.

20 A Correct.

21 Q And in this case the provider would be Ms. Dillon-McGowan.  
22 And she instructed him to bring to medical for assessment. What  
23 is further assessment? What do you understand that to be?

24 A That he would be assessed at the medical unit.

25 Q Okay. And the next entry, does that seem to indicate that

1 Ms. Young brought the patient over to the medical unit for  
2 assessment?

3 A Yes.

4 Q Okay.

5 A Patient brought over to medical for assessment.

6 Q Okay. And again it appears his vital signs were taken.

7 A Correct.

8 Q Blood pressure, heart rate. Is that -- and then is there  
9 any significance of his blood pressure and heart rate to you?

10 A His heart rate is low.

11 Q Okay. And what, if anything, could that be an indication  
12 of or what significance?

13 A From vomiting you can get what's called vagal. You can  
14 actually lower your heart rate when you're vomiting.

15 Q Okay. And what does the term afebrile mean?

16 A Afebrile means without fever.

17 Q Okay. And what, if any, significance is that?

18 A Just that he doesn't have a fever.

19 Q Okay. And previously you mentioned that you're suspecting  
20 acute appendicitis. What were the criteria that you were using  
21 to determine or what were the factors that led you to come up  
22 with that being a differential diagnosis?

23 A Abdominal tenderness.

24 Q Okay. Anything else?

25 A Nausea.

1 Q Okay.

2 A And now vomiting.

3 Q Okay. What are -- have you heard or is pain in the right  
4 lower quadrant an indication of appendicitis?

5 A It can be.

6 Q But does it always have to be present to be diagnosed with  
7 appendicitis?

8 A No.

9 Q Okay. And what about rebound tenderness? Is that a  
10 potential symptom of appendicitis?

11 A It can be.

12 Q Okay. Can you have appendicitis without having rebound  
13 tenderness?

14 A Yes.

15 Q Okay. And what about the fact of a high fever? Is that a  
16 symptom of appendicitis?

17 A No. It's a very general symptom.

18 Q Okay. I mean, if a patient -- so the fact that the patient  
19 does not present with a high fever, can you exclude appendicitis  
20 from a differential diagnosis?

21 A No. No.

22 Q Why not?

23 A Because it's not always associated with a fever.

24 Q Okay. And what is the significance of -- withdrawn. Now  
25 looking at this chart on, again, this note that's dated 4/17 at

1 3:39. It says, "Patient vomited once in medical." Do you see  
2 that?

3 A Correct.

4 Q Okay. So now based upon the note we just read earlier when  
5 the Plaintiff says he's still vomiting, now is an indication  
6 that he vomited again, is that right?

7 MR. NINOSKY: Objection as to leading, Your Honor.

8 THE COURT: I'll sustain the objection.

9 BY MR. SALEEM:

10 Q Okay. What, if anything, is significant to you that the  
11 patient vomited in the medical unit having previously mentioned  
12 that he was still vomiting?

13 A That whatever condition is going on is certainly not  
14 resolved and appears to be getting worse.

15 Q And in this case it mentions that Ms. Young then spoke to  
16 Ms. Dillman-McGowan. It says, "Provider called." What  
17 instructions did she give to Nurse Young?

18 A Try to drink and eat something and ordered CMP and CBC  
19 stat.

20 Q What, if anything, is significant of the fact that she was  
21 ordering to try to drink and eat something? Let me ask you this  
22 way, Doctor. If you were -- I think previously you said that if  
23 you were suspecting someone of acute appendicitis you would not  
24 want to give them anything by mouth, is that fair?

25 A Right. And we generally would not feed somebody vomiting.

1 Q Okay. So does the fact that Ms. McGowan ordered Mr.  
2 Rodriguez to try to drink and eat something, does that indicate  
3 to you that she was not considering appendicitis as a  
4 differential diagnosis?

5 A Yes.

6 Q Okay. And that is fair to say because we previously  
7 discussed that they were anticipated to be GI onset based upon  
8 what we read before?

9 A Yes.

10 Q Okay. And what are CMP and CBCs? Are those blood tests,  
11 Doctor?

12 A CBC is a complete blood count looking at the white count.  
13 CMP, I'm not sure if they are ordering electrolytes or what is  
14 ordered in that test at that facility.

15 Q Okay.

16 A It goes electrolytes like potassium or goes by many  
17 different names.

18 Q Okay.

19 A I'm not exactly sure what's included in that test.

20 Q Okay. And CBC is -- and what would be the purpose in  
21 ordering those tests?

22 A To see if the white cell count is elevated.

23 Q Okay. And the term stat, what does that mean?

24 A That means rapidly.

25 Q Okay. In a hospital setting, have you given orders that

1 you would want to be filled out stat?

2 A Yes.

3 Q Okay. And what is your expectation as to how soon those  
4 orders would be filled out?

5 A In a hospital setting stat means right away.

6 Q Okay. And what would you anticipate it to be in a jail  
7 setting?

8 MR. NINOSKY: Objection.

9 THE COURT: Sustained.

10 BY MR. SALEEM:

11 Q And right away means within how many minutes or hours or  
12 how would you calculate that?

13 A Depending upon what you're ordering.

14 Q Well, in this case if you're ordering blood tests stat.

15 A If I'm ordering blood tests, the blood test would be done  
16 stat, reasonably within 15 to 20 minutes in the hospital,  
17 availability within an hour to 2 hours.

18 Q Okay. And meaning you would get the results within two  
19 hours.

20 A Correct.

21 Q Okay. And I just want to look at -- I'll show you PCM94.  
22 What is PCM94? What type of document is it?

23 A It's a lab results slip.

24 Q Okay. And I'm just going to show you. Does it appear as  
25 if it was ordered by Ms. McGowan?

1 A Yes.

2 Q Okay. And what is the date that it was collected on?

3 A April 17th, 04:00, 4:00 in the morning.

4 Q Okay. And date collected means the date that the blood was  
5 actually collected from the patient?

6 A Correct.

7 Q Okay. And what does the date received mean?

8 A Date received means at what time was it received in the  
9 lab.

10 Q In the lab, okay. So it was collected at 4:00 a.m., but  
11 the lab only collected it at 11:32 p.m.

12 A Correct.

13 Q Okay. And what, if any, significance is there, the fact  
14 that there was a almost 16 hour delay in collecting it?

15 A Well, you can have degradation of the blood in the test if  
16 you wait that long.

17 Q And what do you mean? When you say degradation, what do  
18 you mean?

19 MR. NINOSKY: Objection. Outside the scope.

20 THE COURT: I'll overrule the objection.

21 THE WITNESS: If the blood is sitting around for a  
22 long period of time, it does have a preservative in it, but  
23 certain of the numbers can be less accurate after a long period  
24 of time.

25 BY MR. SALEEM:

1 Q And what is the date of the report?

2 A 4/18, 6:55.

3 Q And what does that mean? What does that date mean?

4 A That means it was the next day at 6:55 in the morning.

5 Q That's when this report was generated?

6 A Yes.

7 Q Okay. And in the treating of appendicitis, would part of  
8 your assessment be conducting a blood test to look for white  
9 blood cell counts?

10 A Yes.

11 Q Okay. And of what significance or what role would you  
12 place on those tests?

13 A White blood cells are -- it's a generalized test. It's not  
14 specific for appendicitis. The white blood cell count can go up  
15 in appendicitis. It doesn't always go up.

16 Q Okay. So the fact that if the white blood cell count was  
17 normal, it did not show any elevation, could you rule out  
18 appendicitis?

19 A No.

20 Q Okay. And I'm just going to show you what's been marked as  
21 -- so after Mr. Rodriguez was seen in the early morning hours of  
22 the 17th does it appear that he was next -- the next time he was  
23 looked at was on April 17th at -- there's an entry that's at  
24 least indicated it's 13:35. Do you see that, Doctor?

25 A Yes.

1 Q Okay. And of what significance is it that the patient  
2 stated that he was feeling weak and having no appetite?

3 A That he's not improving.

4 Q Okay. And what about the fact that he -- what is no  
5 emesis? I'm probably not pronouncing that --

6 A That's no vomiting.

7 Q Okay. And it says, "No vomiting since early a.m." Does  
8 that indicate that he vomited? What does that indicate to you?

9 A That he vomited earlier previous to that.

10 Q Okay. And what significance is there, the fact that he's  
11 reported eating nothing for breakfast and a small amount for  
12 lunch?

13 A That he doesn't feel well.

14 Q Okay. And if a patient presented with these symptoms, how  
15 would you describe the patient's conditions from when we first  
16 started talking about him when he was first seen on the 16th?

17 A Well, that he's no better and appears to be worse.

18 Q Okay. What would the appropriate course of action to be  
19 taken at this point?

20 A To have somebody evaluate him.

21 Q And when you say somebody --

22 A So somebody of a higher level.

23 Q Okay. Higher level than a licensed practical nurse or a  
24 registered nurse.

25 A Correct.

1 Q Okay. Okay. And I'll just show you now what's been marked  
2 -- and just the term, just to be clear, it says, "0600 and 1200  
3 med pass." That's 6:00 a.m. and 12:00 p.m.

4 A Correct.

5 Q Okay. And the next entry that appears to be was at April  
6 17th at 19:11 appears to be the note. Do you see that?

7 A Yes.

8 Q And it's 1900 med pass. Is that 7:00 p.m.

9 A Yes.

10 Q Okay. And this is a note again by Susan Roberts, right?

11 A Yes.

12 Q And Susan Roberts we mentioned saw him the day earlier,  
13 right?

14 A Yes.

15 Q She made the initial assessment, right?

16 A Yes.

17 Q Okay. And again, her note notes that patient was  
18 complaining of abdominal pain.

19 A Yes.

20 Q And this is now abdominal pain that he's been complaining  
21 of when she talked about him yesterday on the 16th she said it  
22 had been going on for two days.

23 A Correct.

24 Q Okay. So now this would be if she's seeing him on the 17th  
25 it would potentially be three days.

1 A Correct.

2 Q Okay. And thus far, is there any indication in the records  
3 that he had been seen by any provider, either a doctor, a  
4 physician's assistant, or a certified registered nurse  
5 practitioner?

6 A No.

7 Q Okay. And would that be something that you would have  
8 expected him to see at this point, to be seen at least by one of  
9 those three types of individuals?

10 MR. NINOSKY: Objection.

11 THE COURT: Counsel, please approach.

12 (Sidebar from 2:03 p.m. to 2:12 p.m.)

13 THE COURT: Ladies and gentlemen, rather than having  
14 you sit there while we're discussing this matter, I'm going to  
15 take a 15-minute recess. I'm going to again remind you that you  
16 should keep an open mind about this case until all the evidence  
17 is in on both sides. So you should remain from discussing with  
18 each other or with anyone else including members of your family  
19 or allow anyone to talk to you about it. Do not form any  
20 opinions about this case until you retire to the jury room after  
21 my charge.

22 We'll stand in recess for 15 minutes.

23 THE BAILIFF: All rise.

24 (Jury excused)

25 THE COURT: And I think, Doctor, for this discussion,

1 it might be best if you step outside.

2 THE WITNESS: Yes.

3 THE COURT: Thank you.

4 You may be seated. The record will reflect that the  
5 jury is no longer present and also that the witness, Dr. Brown,  
6 has stepped out of the Courtroom.

7 I just want to make sure that the theory of the  
8 Plaintiff is not moving away from the report and away from the  
9 original claim. And so I want to give everyone a chance to  
10 reread the expert witness disclosure. If there is no question  
11 that he opines within a reasonable degree of medical certainty  
12 that the staff departed from the standard of medical care when  
13 they failed to recognize obvious signs of appendicitis. Now  
14 here it says, "Failed to order proper diagnostic testing," but  
15 I'm not sure what that proper diagnostic testing he believes  
16 should have been ordered other than what would have been  
17 available at a hospital. Because he does say later on in the  
18 report, he talks about diagnostic tests that would have been  
19 performed if they had gotten him to a hospital.

20 It was, "During the prevalence of this condition, I  
21 have seen a number of cases involving." Yeah, he talks about in  
22 paragraph 16, "There are other symptoms associated with  
23 appendicitis such as vomiting and diarrhea and high temperate,  
24 but an appropriate abdominal examination is often key in  
25 diagnosing this condition."

1           Then it goes to 17. "While some scans such as a CT  
2 scan can help confirm or rule out a suspicion of appendicitis,  
3 it is common knowledge among healthcare professionals that a  
4 diagnosis of appendicitis is made by way of a proper clinical  
5 assessment. This involves taking a full history of the  
6 patient's symptoms, how the symptoms have worsened, and by  
7 performing a physical examination of Plaintiff. If following  
8 such an assessment a strong index suspicion of appendicitis  
9 remains, a patient will often be listed for surgery, which can  
10 be carried out by keyhole surgery." Then he goes on to talk  
11 about that, but that's far less invasive.

12           And he also talks about at paragraph 22 where there's  
13 a broader discussion of 21 about delays in obtaining an  
14 appropriate diagnosis. "The delay in diagnosis of appendicitis  
15 is unreasonable because Mr. Rodriguez presented with complaints  
16 of right lower quadrant pain days before his hospitalization.  
17 Diagnostic aids can dramatically reduce negative appendectomies,  
18 perforations, and hospital stay. These aids are laparoscopy,  
19 scoring systems, ultrasonography, and computed tomography.  
20 Unfortunately, Mr. Rodriguez was not properly assessed until he  
21 got to the hospital."

22           So I think that is when you're trying to suggest that  
23 the hospital personnel failed to assess him, those are the areas  
24 where there is a failure to assess, correct? And, Mr. Ninosky,  
25 would you agree with that?

1 MR. NINOSKY: Yeah. I'm taking it as when they -- as  
2 we discussed at sidebar. That there was an assessment done,  
3 information obtained, and there was a failure to recognize after  
4 that assessment that it was appendicitis. That, to me, is what  
5 is discussed. And that, to me, is what the theory of the case  
6 is about.

7 THE COURT: Attorney Saleem, what are your thoughts?

8 MS. RAMEAU: I'm sorry.

9 MR. SALEEM: I'm just going to defer to Ms. Rameau,  
10 Your Honor.

11 THE COURT: Oh, certainly.

12 MS. RAMEAU: It's paragraph number 22, correct, Your  
13 Honor?

14 THE COURT: Right. The issue that was before us, and  
15 that's what the objection was, was whether Dr. Brown in his  
16 report -- and he was not deposed, is that correct?

17 MR. NINOSKY: No, no depositions have been taken.

18 THE COURT: So in his report did he opine that one of  
19 the areas where -- and I'm going to get the exact name -- where  
20 Ms. Dillman-McGowan, Nurse Dillman-McGowan, did he opine that  
21 one of the things that she did that fell below the applicable  
22 standard of care was she did not come to the prison earlier to  
23 do a onsite physical assessment of Mr. Rodriguez?

24 MS. RAMEAU: Well, that's not specifically in the  
25 report, but I think it's inherent in the doctor's report and his

1 opinions that there was a delay. And to the extent that there  
2 was a delay in making the diagnosis, the only Defendant in this  
3 case who was in a position to make any kind of a diagnosis is  
4 Ms. Paula Dillman-McGowan. No one else in this Courtroom can do  
5 that.

6           So, inherent in this document is that her delay in  
7 actually making herself present at the facility in order to make  
8 a proper abdominal assessment contributed to -- caused, rather -  
9 - caused the delay in the diagnosis. And it's one thing to get  
10 information second-hand or third-hand from an LPN or an RN.  
11 It's another for a medical provider, a physician or a nurse  
12 practitioner, to actually be present at the facility and to  
13 conduct the examination themselves, and I think that the doctor  
14 was clear in that.

15           THE COURT: Well, he does say at paragraph 5 that the  
16 staff -- one of the problems with this report is he never breaks  
17 down the negligence of each individual Defendant. And we have  
18 individual Defendants that are all on trial here, that are all  
19 personally liable for their part in what's alleged to have  
20 happened here. So that does make it a problem. It would be a  
21 whole lot easier if he said, "This is what certified registered  
22 nurse practitioner Paula Dillon-McGowan did wrong. This is what  
23 Susan Roberts, LPN, did wrong." He doesn't do that.

24           So when he says, "The staff departed from the  
25 applicable standard of care when they failed to recognize

1 obvious signs of appendicitis, failed to order proper diagnostic  
2 testing, and failed to transfer Mr. Rodriguez to a facility  
3 capable of performing such testing."

4 I'm not sure that means that in order to do it  
5 properly and to meet the standard of care Paula Dillon-McGowan  
6 had to come to the facility at an earlier time. I don't know  
7 how you read that into that. But I understand your argument  
8 that he's just broadly saying they should do more and now at  
9 trial he's going to get into specifics.

10 The problem is that's really putting the Defense in an  
11 untenable position that suddenly things that he didn't say were  
12 -- like the blood test. That the blood test -- I think there  
13 was a suggestion that the blood test was not tested in a timely  
14 fashion once the blood had been drawn. There is nothing in this  
15 report to suggest that that's what led to a misdiagnosis or that  
16 that fell below the standard of care, yet that's what the jury  
17 heard was -- or at least was an insinuation that maybe this  
18 blood test wasn't accurate because the blood wasn't tested in a  
19 timely fashion.

20 That's brand new to the Defense because they would  
21 never have known that they should have someone who could opine  
22 on a blood test because there's nothing in here to suggest the  
23 blood test wasn't tested in a timely fashion. And that's the  
24 whole purpose of the report is so they can be put on notice so  
25 they can address those issues with the jury. And I would be

1 fairly certain that the responsive expert opinion from the  
2 Defense is not even going to mention a blood test, other than  
3 the fact that one was done and it showed that there was no  
4 problem with the white blood count.

5 MR. NINOSKY: That's correct, Your Honor.

6 THE COURT: So I guess the issue is the law is clear  
7 that the witness cannot testify outside the scope of his report.  
8 Sometimes it is difficult to define where those lines are drawn,  
9 when it actually goes outside the scope and when it is  
10 legitimate that the Defense should have been put on notice that  
11 this was part of what he was going to claim was the negligence  
12 in this matter or the delivered indifference. There is no  
13 question the blood test is not in this report and that should  
14 not have gone to the jury.

15 This issue of whether Ms. McGowan should have come in  
16 earlier, is that reasonably contained within the idea that  
17 that's why they failed to diagnose in a more expeditious  
18 fashion? I know you believe it is.

19 MS. RAMEAU: I believe it is, Your Honor. I believe  
20 it is.

21 THE COURT: And what else? Like what diagnostic tests  
22 should they have performed? Like is he going to testify as we  
23 go to that paragraph that listed all the diagnostic testing that  
24 could be performed?

25 MS. RAMEAU: Well, certainly the CT scan he mentions

1 in the report.

2 THE COURT: But he's not going to suggest they could  
3 have done a CT scan, correct?

4 MS. RAMEAU: No, of course not, Your Honor.

5 THE COURT: Because I don't think -- they should have  
6 sent him to the hospital earlier.

7 MS. RAMEAU: Right.

8 THE COURT: And they should have sent him to the  
9 hospital earlier because they should have recognized that he had  
10 appendicitis. That's what the doctor is really saying is that -  
11 -

12 MS. RAMEAU: Yes.

13 THE COURT: -- not that they should have performed  
14 these tests, but that they should have gotten to the hospital  
15 quicker.

16 MS. RAMEAU: So that he could be subjected to these  
17 tests because obviously they don't have the facilities at the  
18 prison for him to be put into a CT scan machine.

19 THE COURT: Right. So I believe this report is saying  
20 based on the information they had they should have diagnosed him  
21 with an appendicitis earlier, that any doctor would have  
22 recognized this was appendicitis earlier. Maybe a nurse would  
23 have recognized this was appendicitis and gotten him to the  
24 hospital right away, not that they should have done more to tell  
25 whether it wasn't appendicitis, that they should have known it

1 from the information they had. I think that's what he's saying.

2 MS. RAMEAU: And in addition to that, if I may, Your  
3 Honor.

4 THE COURT: Certainly.

5 MS. RAMEAU: The report also said that they should  
6 have transferred him to a facility capable of conducting --

7 THE COURT: Yes.

8 MS. RAMEAU: -- proper diagnostic testing.

9 THE COURT: In other words, they should have  
10 recognized that this was a problem that needed him to get to the  
11 hospital right away, not Nurse McGowan should have come in, not  
12 they should have seen him more times during the day, not that  
13 they should have done more testing on him, but they didn't need  
14 to do any more. They should have known that he had this problem  
15 and gotten him to a hospital where he could have gotten these  
16 tests that the doctor lists. I think that's what the report  
17 says.

18 MS. RAMEAU: Yes, Your Honor.

19 THE COURT: Take a look at the report.

20 Mr. Ninosky, do you wish to be heard?

21 MR. NINOSKY: No. I was just going to say that's  
22 exactly -- I will represent to the Court that what you just said  
23 is how this case has been defended based upon the report that's  
24 been prepared which was they should have diagnosed it based upon  
25 that symptomology, not about any specifics about Ms. Dillon-

1 McGowan should have come in sooner. She should have done this  
2 or that. It's that these are the symptoms, such as the lower  
3 right quadrant pain, which he describes in there. It should  
4 have been a red flag to send the guy out.

5 THE COURT: Right.

6 MR. NINOSKY: That's been their theory. Now we're  
7 bringing in the other things as the Court's recognized.

8 THE COURT: In fact, what supports that theory is the  
9 fact that he didn't break down the individual Defendants. He  
10 saw this as a failure to diagnose, not a failure to test, not a  
11 failure to -- but a failure of the entire staff, given  
12 everything they did -- and not suggesting that they did anything  
13 wrong except that they failed to diagnose it as an appendicitis  
14 when they did what they did. That all of -- I think that's what  
15 he's saying, that they should have gotten him to the hospital  
16 right away and not that any individual Defendant did anything  
17 wrong other than they failed to diagnose this as appendicitis.

18 But take a look at the report. It's relatively short.  
19 Read it again. See if there's something different and where  
20 maybe some actions of individual Defendants might appropriately  
21 be addressed by the doctor, but I think that his report focuses  
22 on failure to diagnose, get him to the hospital where they could  
23 do better testing and testing that could only be done in the  
24 hospital such as the CT scan, and get him operated on right away  
25 because if he'd been operated on right away it would have --

1 hopefully it would not have perforated and caused a greater  
2 problem.

3 But take a look at it. I'll come in before we bring  
4 the jury in just to address it to make sure that we stay within  
5 the bounds of the report, but I don't want to unduly hamper your  
6 ability to get the whole information about what happened to the  
7 jury, but at the same time, it's incumbent on me not to allow a  
8 new theory to be introduced that the Defense had no idea was  
9 going to be introduced to this jury and accordingly would have  
10 no way to address it other than asking their expert to testify  
11 outside the scope of his or her report, but that's not what the  
12 reports are for.

13 MR. NINOSKY: And even -- and again, respectfully, at  
14 this stage of the game it's impossible to even prepare my  
15 witnesses to give adequate testimony even if it would be outside  
16 the scope.

17 THE COURT: All right. Take a look at the reports.  
18 We'll discuss this for a few minutes before we bring the jury  
19 back in and we'll --

20 MS. RAMEAU: How long do we -- I'm sorry, Your Honor.  
21 How long do we have?

22 THE COURT: How long would you like? Fifteen minutes?

23 MS. RAMEAU: That's fine.

24 THE COURT: Sure. Let's stand in recess for 15  
25 minutes

1 THE BAILIFF: All rise.

2 (Recess taken at 2:27 p.m.)

3 THE COURT: -- it was properly.

4 MS. RAMEAU: Well, I think it's clear from the report,  
5 Your Honor --

6 THE COURT: Okay.

7 MS. RAMEAU: -- that Dr. Brown intended that part of  
8 his opinion be that had Rafael Rodriguez been sent to a hospital  
9 soon he would have been subjected to proper diagnostic tools and  
10 tests that would have yielded the proper diagnosis.

11 THE COURT: I agree.

12 MS. RAMEAU: I think that that's clear.

13 In addition to that, I think that what's inherent in  
14 this report is that the individual responsible for making the  
15 diagnosis, Defendant Paula Dillman-McGowan, that her conduct  
16 fell below the standard of care when she failed to adequately --  
17 properly, rather -- diagnose Mr. Rodriguez with appendicitis.  
18 But I think that what is also inherent in the opinion is that  
19 she also failed to conduct a proper assessment to the extent  
20 that she deferred on a number of days to assessments conducted  
21 by LPNs, right. And she's the one in charge of these LPNs.

22 But I understand it doesn't specifically say this in  
23 the report, but I think that it is inherent in the report that  
24 Defendant Paula Dillman-McGowan, that her conduct specifically  
25 fell below the standard of care when she failed to conduct her

1 own assessment and relied on assessment conducted by the LPNs in  
2 this case, LPN and RN.

3 THE COURT: Mr. Ninosky, what is your thought?

4 MR. NINOSKY: I respectfully disagree. That's not  
5 anywhere inferred in that report. The report is pretty clear  
6 that based upon the symptomology that was presented, and  
7 frankly, what was reported to Paula Dillman-McGowan, should have  
8 been in this expert opinion sufficient for a diagnosis of an  
9 appendicitis. Then he should have been sent out for whatever  
10 diagnostic testing or treatment was necessary. Not that she  
11 needed to do an independent assessment, not that she should have  
12 come in any sooner to do so. That isn't anywhere addressed in  
13 the report.

14 THE COURT: I wonder if we should bring Dr. Brown in  
15 and ask him. I'm not suggesting that he can suddenly amend his  
16 report, but I wouldn't be at all surprised if he said, "No, I  
17 didn't mean she should have come in earlier. I meant," because  
18 if I just look at his report, what he seems to me is this was so  
19 obvious. And I think he even said this about the OB/GYN. This  
20 is so obvious that anybody would have seen it and they would  
21 have sent him to a hospital, not that we had to do more to see  
22 what the problem was or come in and do more, that this was so  
23 obvious from the information available to them that Mr.

24 Rodriguez should have been sent to a hospital right away.

25 I believe that's what Dr. Brown is saying in this

1 report and I believe that's what he would say if he was asked.  
2 I don't believe he would say that Ms. Dillman-McGowan should  
3 have come in earlier. I don't think he would say, "That's what  
4 I mean here is she should have come to the prison quicker. It's  
5 that she should have realized this was an appendectomy based  
6 upon the information she had available to her."

7           And then when we start giving different reasons why  
8 the Defendant should have done things differently, he's not  
9 saying they should have done anything differently except he does  
10 say, "Get diagnostic testing." But then when you go like in  
11 paragraph 20, 21, and especially 22 where he says, "Diagnostic  
12 aids can dramatically reduce negative appendectomies,  
13 perforations, and hospital stay." But then he talks about these  
14 aids and he says Mr. Rodriguez was not properly assessed until  
15 he got to the hospital. So he talks about laparoscopy, scoring  
16 systems, ultrasonography, and computed tomography.

17           So I don't mind him saying that they didn't do those  
18 things and they should have done them if that's what he means by  
19 that, they should have done them and they didn't. I don't mind  
20 him saying, "How was he not -- how was Mr. Rodriguez not  
21 properly assessed?" Because he clearly says he was not properly  
22 assessed. I mean, it would have been nice if there was a little  
23 more detail on it, but he clearly says he was not properly  
24 assessed, clearly says the diagnosis was untimely, and clearly  
25 says he should have been sent to the hospital earlier and it

1 would have avoided all the problems that he suffered. So  
2 clearly the doctor can testify about all of that.

3 And then I don't know because the report isn't  
4 specific enough how far he can go beyond that to say what should  
5 have been done differently to diagnose, but I'll certainly let  
6 you get into that because he says there was not a proper  
7 assessment and a proper diagnosis. I'll let you get into that  
8 to an extent, but as soon as it starts getting into conduct that  
9 he doesn't talk about at all such as nowhere does he say or even  
10 allude to the fact that Ms. Dillman-McGowan fell beneath the  
11 standard of care because she tried to do this diagnosis based on  
12 information that was being done by the RNs or the LPNs. He just  
13 doesn't say it. He doesn't even allude to it unless you just  
14 completely read it because we know the facts, but he knew the  
15 facts too. He knew the facts too and if he thought that that  
16 was negligent behavior, he, I presume, would have put in his  
17 report that that was negligent behavior.

18 Do you want to hear from the doctor outside the  
19 presence of the jury to see what he meant in his report or would  
20 that just be superfluous?

21 MR. NINOSKY: To me, at this point it is because  
22 irrespective of what he says, we're still with what the document  
23 says and what clearly what was conveyed to the Defense and how  
24 we had to defend against what his opinion was.

25 MS. RAMEAU: Your Honor, I think that we should hear

1 from the doctor so you get a sense of, you know, what perimeter  
2 beyond the four corners of the document is acceptable.

3 THE COURT: Let's do it. Would you have the doctor  
4 come on in?

5 Doctor, sorry you've been held out there for so long  
6 and please have a seat, sir.

7 THE WITNESS: Thank you.

8 THE COURT: The issue that's before the Court right  
9 now, of course, is in your report you said that it's your  
10 opinion within a reasonable degree of medical certainty that  
11 PrimeCare staff departed from the applicable standard of medical  
12 care when they failed to recognize obvious signs of  
13 appendicitis, failed to order proper diagnostic testing, and  
14 failed to transfer Mr. Rodriguez to a facility capable of  
15 performing such testing. And that's your opinion, correct?

16 THE WITNESS: Yes.

17 THE COURT: You were asked right before we broke.

18 THE WITNESS: Right.

19 THE COURT: First of all, you were asked about a blood  
20 test. Nowhere in here did you suggest that the blood test was a  
21 problem. Do you believe the blood test was a problem?

22 THE WITNESS: No.

23 THE COURT: And then you were asked about whether  
24 Paula Dillman-McGowan, the CRNP, should have come to the prison  
25 earlier, but nowhere in here do you say anything about that she

1 couldn't make the diagnosis based on information that was  
2 provided by the other onsite care professionals. Did you mean  
3 to say that or --

4 THE WITNESS: Well, and you can correct me if I'm  
5 wrong.

6 THE COURT: Oh, certainly, sir.

7 THE WITNESS: My understanding that a licensed  
8 professional cannot practice differently in a prison as they  
9 would practice in any other facility.

10 THE COURT: Right.

11 THE WITNESS: If they're licensed in Pennsylvania.  
12 And the second thing, it's my understanding that in the  
13 treatment of prisoners that the prisoner has the right to prompt  
14 medical assessment that would be your general understanding of  
15 what the medical assessment would be. In my reading of the  
16 records, the system in evaluating this gentleman is that a  
17 higher level of practitioner should have seen the patient. You  
18 know, that he was on Wednesday and Thursday he had the  
19 complaints, but he was not seen by somebody higher than an LPN  
20 or an RN at any time, especially on Friday, Saturday, or Sunday,  
21 and then presents to the hospital on Monday.

22 And I think that as my understanding of the law is  
23 that there was a breach in the standard of care because he was  
24 not properly assessed by the level of practitioner and that they  
25 did not -- if a level of practitioner had assessed him in a

1 proper manner, which is in person, they would have made a  
2 diagnosis sooner. And it is that, and I feel that that's a  
3 breach of the standard of care for a gentleman to go five days  
4 and have not been seen by someone higher than an RN.

5 THE COURT: Okay. So --

6 THE WITNESS: And I think that's inconsistent with the  
7 practice of treating criminals.

8 THE COURT: And so you believe if the higher level  
9 person had seen him earlier --

10 THE WITNESS: Correct.

11 THE COURT: -- the would have realized this was an  
12 appendectomy.

13 THE WITNESS: Well, you don't have to --

14 THE COURT: Or an appendicitis. I'm sorry.

15 THE WITNESS: You don't have to make the diagnosis of  
16 appendicitis. You should assess the patient and realize is the  
17 patient well enough to be kept at the facility or does the  
18 patient need to be moved to another level of care. I can make  
19 the diagnosis of appendicitis at the hospital, but we never had  
20 that opportunity because he was not properly assessed and sent  
21 to the hospital. They didn't recognize that he was getting  
22 sicker and sicker and sicker and they should have recognized  
23 that.

24 THE COURT: Now, so it's not that they should have  
25 realized it was appendicitis, but they should have realized he

1 was getting sicker and sicker so that he could be sent to the  
2 hospital where proper testing could have been done to identify  
3 that he was ill.

4 THE WITNESS: Right. And one of the ways you realize  
5 that he's getting sick is having, you know, a differential  
6 diagnosis of what could be wrong with this gentleman. And  
7 appendicitis is what he had. He showed signs and symptoms of  
8 appendicitis. But I'm not saying that they're at absolute fault  
9 because they didn't say, "Oh, he has appendicitis." They didn't  
10 assess him properly to say, "He needs to go to the hospital to  
11 be assessed by a physician or a higher level of care or to get a  
12 CT scan or to do something."

13 THE COURT: Because he's getting sicker. He's not  
14 getting better.

15 THE WITNESS: He's getting worse. Yes. And you can  
16 see, okay, the first 24 hours, okay. The second 24 hours, okay.  
17 72 hours, okay. But now 5 days and to show up at the hospital,  
18 you know, midday on Monday, you know, in extraneous (phonetic).

19 THE COURT: Okay. Attorney Saleem, do you wish to  
20 question the doctor at all?

21 MR. SALEEM: No, Your Honor.

22 THE COURT: Mr. Ninosky, do you have any questions?

23 MR. NINOSKY: I'd like to know what the Court's ruling  
24 is going to be before I do because, Doctor, you would agree with  
25 me what you just said to the Judge isn't in this report?

1 THE WITNESS: It is that I thought that, but that the  
2 company that runs the healthcare for the prison is in breach of  
3 the standards.

4 MR. NINOSKY: Doctor, I don't see that anywhere where  
5 you say that the company -- with how --

6 THE WITNESS: Isn't that the PrimeCare?

7 THE COURT: PrimeCare is the company.

8 THE WITNESS: PrimeCare.

9 MR. NINOSKY: Let me finish.

10 THE WITNESS: Okay.

11 MR. NINOSKY: Okay. I don't see anywhere in here  
12 where you have any criticisms about how healthcare itself is  
13 rendered. And, in fact, upon direct before you started on  
14 qualifications, I specifically asked you questions. You don't  
15 know how healthcare is run in a prisoner setting, correct?

16 THE WITNESS: No, that's not correct. I don't know  
17 the policies of that specific prison. I know I've reviewed the  
18 record of this specific case.

19 MR. NINOSKY: Right.

20 THE WITNESS: And, you know, when you said by an  
21 expert in prison policy, no, but it's my understanding that I  
22 know what the scope of practice is for an LPN.

23 MR. NINOSKY: Right.

24 THE WITNESS: I know what the scope of practice is for  
25 an RN.

1 MR. NINOSKY: Right.

2 THE WITNESS: And a reasonable standard is that a  
3 prisoner must be given reasonable healthcare.

4 MR. NINOSKY: Right. Uh-huh.

5 THE WITNESS: Right.

6 MR. NINOSKY: And he was assessed by nursing staff,  
7 right?

8 THE WITNESS: Correct.

9 MR. NINOSKY: The provider was called with  
10 symptomology, correct?

11 THE WITNESS: Correct.

12 MR. NINOSKY: That provider issued orders, correct?

13 THE WITNESS: Correct.

14 MR. NINOSKY: He was monitored for multiple days for  
15 vital signs and any other symptoms or complaints, correct?

16 THE WITNESS: No, not correct.

17 MR. NINOSKY: Doctor, you're disagreeing with me that  
18 on Saturday and Sunday his vital signs were taken both times?

19 THE WITNESS: Vital signs is not a proper assessment.

20 MR. NINOSKY: Well --

21 THE COURT: Well, let me interrupt you for a minute,  
22 Counselor. And I apologize.

23 MR. NINOSKY: Okay.

24 THE COURT: Nowhere do you suggest that -- and I'm  
25 getting back to this issue because that's what was right before

1 the Court -- that certified registered nurse practitioner Paula  
2 Dillman-McGowan should have actually come to the facility to  
3 make a diagnosis at an earlier time. I think -- right? Is that  
4 correct?

5 THE WITNESS: Okay. No. I think -- what did I state  
6 about that? I thought that she breached the standard.

7 THE COURT: You never even mentioned her name, but you  
8 did say that the PrimeCare staff.

9 THE WITNESS: Correct.

10 THE COURT: So let's say she's PrimeCare staff.  
11 Failed to recognize obvious signs of appendicitis, failed to  
12 order proper diagnostic testing.

13 THE WITNESS: Yes.

14 THE COURT: And failed to transfer Mr. Rodriguez to a  
15 facility capable of performing such testing. What I interpret  
16 from that is not that they should have done more, but that --  
17 well, from what you just said -- but they should have realized  
18 his condition was worsening.

19 THE WITNESS: Correct. And --

20 THE COURT: They shouldn't have even known it was  
21 appendicitis from what you just said.

22 THE WITNESS: Well, had that nurse practitioner seen  
23 the patient and examined the patient, because examining the  
24 patient is, you know, an abdominal assessment is actually beyond  
25 the scope of an LPN and an RN. And so she didn't come on Friday

1 to see him and to examine him and then he didn't have a proper  
2 assessment on Saturday or Sunday. All he had was vital signs of  
3 my reading of the record. The only thing in the record is vital  
4 signs for Saturday and Sunday.

5 MR. NINOSKY: And no complaints, correct?

6 THE WITNESS: No. No other assessment. I mean,  
7 assessment is, you know, was he getting better, was he getting -  
8 - when he comes to the hospital, the first statement he makes  
9 is, "They told me I couldn't come to the hospital until Monday  
10 to the triage nurse." And then when the ER doc comes in he  
11 tells the ER doc he's been vomiting ten times. And so --

12 MR. NINOSKY: Actually, he said ten times. Then  
13 another time he said 25 times, right? So you would agree with  
14 me there's a lot of inconsistencies as to what he was saying and  
15 you would also agree with me with the lab work that was done you  
16 would expect to see electrolyte issues that weren't present for  
17 somebody who claims to be having those types of symptoms, fair?

18 THE WITNESS: No. They can be non-specific. So you  
19 can see them or not see them.

20 MR. NINOSKY: Okay.

21 THE WITNESS: So, yes, they may be present in 60 to 70  
22 percent of the time, but they're not present in 30 percent of  
23 the time.

24 MR. NINOSKY: Well, Your Honor --

25 THE COURT: All right, Doctor. Thank you.

1           You have no questions, Counsel?

2           MR. SALEEM: No, Your Honor.

3           THE COURT: You may step back out. Thank you.

4           THE WITNESS: Thank you.

5           THE COURT: We're making your afternoon more exciting.

6           And the record will reflect the doctor has left the  
7 courtroom.

8           That makes the situation even a little more difficult.  
9 Now he's not even saying that he meant they should have  
10 diagnosed it as an appendicitis, but rather than I think what he  
11 said was basically they should have seen his condition  
12 deteriorating, got him to a hospital where a hospital could have  
13 done the testing and determined it was an appendicitis.

14           MR. NINOSKY: And the problem with that, Your Honor,  
15 none of those people that were doing those assessments over the  
16 weekend were sued. None of them are parties in this case. So  
17 he doesn't identify them. They are not sued. And now he's  
18 going to say that they had deficient assessments on people that  
19 aren't even parties in this case.

20           MS. RAMEAU: That's not what he's saying. He's saying  
21 that --

22           MR. NINOSKY: That's what I just heard.

23           MS. RAMEAU: -- he was getting progressively worse  
24 from the time he first presented with the symptoms, right?  
25 We've got documentation that says that the very first time they

1 put the symptoms down on paper was on the 16th, but that the  
2 symptoms started 48 hours before, which takes us back to the  
3 14th. That from the 14th to the 15th to the 16th he was  
4 deteriorating and he further deteriorated on the 17th. So  
5 whatever happened on the 18th, Your Honor, there's no indication  
6 -- no one's going to be able to argue in this Courtroom that he  
7 was doing well on the 18th given the state of his abdomen. To  
8 make that argument would be completely disingenuous and no jury  
9 would buy it.

10 So whether the individuals who took his vital signs,  
11 not because they were RNs or LPNs or in this lawsuit, is of no  
12 moment, okay. The individual was supervising them. The person  
13 who has the authority to go out and open up a medical practice  
14 is Defendant Paula Dillman-McGowan. She's the one who was in  
15 charge of everyone here. So --

16 THE COURT: But that sounds like you want to release  
17 the other nurses from the case because if you're saying that the  
18 failure was her not coming in earlier, that kind of eliminates  
19 any issues with respect to the other nurses, I think. And I'm  
20 not --

21 MR. NINOSKY: Well, and especially when they've  
22 already conceded, and I haven't said anything because I'm  
23 waiting to make my motion. They've already conceded that these  
24 nurses can't diagnose. And then he's not done testifying yet,  
25 but I mean that was a specific statement that was made. So if

1 they cannot diagnose within their scope of practice, well, then  
2 the failure to diagnose can't be on these nurses. So I agree.  
3 The nurses shouldn't be here.

4 MS. RAMEAU: But there's more --

5 MR. NINOSKY: Now we're still going to argue about  
6 respectfully what the doctor should be able to say relative to  
7 Paula Dillman, but from a nursing perspective, they're not able  
8 to diagnose. And as such, how can you have a failure to  
9 diagnose when they, as a matter of their nursing licenses, can't  
10 diagnose. Only thing they can do is assess, report, get a  
11 history, and give information to somebody else to make a  
12 decision, which is what happened here.

13 MS. RAMEAU: Assuming that that's true, okay, assuming  
14 that that's true, there's still the issue of the deliberate  
15 indifference of the other two Defendants, Your Honor. And I  
16 think that that issue is still -- you know, we can still  
17 establish that certainly, given the record and given the  
18 interactions that the other two Defendants had with Mr.  
19 Rodriguez, interactions that are in fact documented in the  
20 medical record.

21 MR. NINOSKY: Well --

22 THE COURT: If you read the --

23 MS. RAMEAU: And we haven't gotten to that yet.

24 THE COURT: I don't know if you've had an opportunity  
25 to read that Pearson case as it addresses the issue of nurses

1 and deliberate indifference, but this is a far cry from making  
2 someone crawl across the floor to get into a wheelchair, which  
3 held that one nurse in in the Third Circuit and said all the  
4 other nurses should probably have been dismissed on deliberate  
5 difference, but that's for another time. I'm sure we'll get  
6 into that at the appropriate time.

7 I think at this point I want you to be able to present  
8 the case you came into this Courtroom intending to present and I  
9 assume that case has to reflect the expert witness report of Dr.  
10 Brown and of the other doctor. Both of them said this was  
11 obvious. They should have known it was appendicitis and sent  
12 him to a hospital.

13 MS. RAMEAU: And I think if I can -- and I understand  
14 what Dr. Brown is saying because I had opportunities to speak  
15 with Dr. Brown myself. So what he's saying, Your Honor, is  
16 that, yes, the symptoms of appendicitis were obvious, right, and  
17 yes, that there was a failure to diagnose, right? But assuming  
18 that, you know, the Defendants didn't have a clue, right?  
19 Assuming that they didn't. Still, his symptoms were  
20 deteriorating, right? He wasn't getting any better. He's still  
21 in a substantial amount of pain, right?

22 And he should have been sent to the hospital given the  
23 fact that, you know, obviously like common sense tells you to  
24 the extent that you give someone Maalox, right. You give them  
25 Pepcid. They gave him a gastric cocktail, Your Honor, that was

1 ineffective. That should have told them that they had to change  
2 their plans and they failed to do that.

3 THE COURT: Right.

4 MS. RAMEAU: So his opinion is really two-fold, right?  
5 They failed to recognize, but even if they were clueless, right,  
6 even if they weren't medical professionals, let's say. Even if  
7 they had no clue, they should have sent him to the hospital  
8 given the fact that his symptoms were deteriorating.

9 THE COURT: And I don't have a problem allowing him to  
10 testify along those lines. What I do have a problem with is him  
11 suddenly saying that Ms. Dillman-McGowan should have come to the  
12 prison at an earlier time when he never says that was the  
13 problem, that she didn't come to the hospital at an earlier  
14 time. That's not fair to her because then she would have an  
15 opportunity to say, "No, I shouldn't have come to the hospital.  
16 I could diagnose this basing on information from the RNs and the  
17 LPNs and that's how it's typically done."

18 So same with the blood test. I can't allow suddenly  
19 the theory to be that they couldn't rely on the white blood  
20 count because the test wasn't done right because the blood was  
21 held out for too long. And he didn't even mean that to be the  
22 case. I don't know how that got before the jury except that I  
23 failed to sustain an objection that was timely made by Mr.  
24 Ninosky.

25 So I will allow you to pursue your theory with this

1 expert, and as I'll explain later, with the other expert. I  
2 just can't let you come into new theories and it's a new theory  
3 that Attorney -- that Nurse Dillman-McGowan should have come to  
4 the prison earlier. That's a new theory not contained here.  
5 And I don't think you even argued it in your opening. The  
6 theory wasn't the failure to come in. The theory was she failed  
7 to diagnose it with the information she had. She didn't need to  
8 come in because it was so obvious she should have known from the  
9 information that was provided by the people onsite.

10 Is that ruling clear?

11 MR. NINOSKY: It is from my perspective. And I would  
12 ask two things. One, that we do have a curative instruction to  
13 the jury that they should disregard any testimony about blood  
14 testing potentially being tainted or otherwise because that's  
15 not at -- no one is going to present any evidence in the case.

16 THE COURT: I'm going to stop there. Attorney Saleem,  
17 do you have any objection to that? I'm asking you since you're  
18 doing the questioning.

19 MR. SALEEM: That's fine, Your Honor.

20 THE COURT: Thank you, sir.

21 MR. NINOSKY: The second thing, and we raised this in  
22 limine, but since we're outside the presence of the jury and I  
23 don't want to have any more slippages that may happen, there's  
24 been nothing that was contained in this report about post-  
25 surgical wound care. And I never heard anything in the opening.

1 I never heard anything -- there's nothing in the reports. And I  
2 just want to make it crystal clear that there's nothing that  
3 this expert can say as to wound care when he came back to the  
4 facility after the original surgery.

5 THE COURT: And I believe we had addressed this in the  
6 motion in limine. I think Attorney Rameau had indicated that  
7 you were not trying to introduce how the wound was cared for in  
8 the prison. Rather, you were trying to introduce that in fact  
9 he had that second surgery as the damages he had as a result of  
10 the first surgery, not that there was further wrongdoing by  
11 prison medical staff subsequent to the surgery, is that correct?

12 MS. RAMEAU: Yes. My recollection of the discussion  
13 we had, Your Honor, is that I'm sure I indicated to the Court  
14 that our position is that the subsequent surgery resulted from  
15 the peritonitis caused by the rupture of the appendix.

16 THE COURT: Right. But it was a consequence of the  
17 initial --

18 MS. RAMEAU: It was a consequence of the first --  
19 right. The second surgery was a consequence of the failure to  
20 diagnose in the first place, the failure to treat timely, right?

21 THE COURT: Right.

22 MS. RAMEAU: I mean, that's our position. We're not -

23 -

24 THE COURT: So you have no objection to the motion in  
25 limine being granted, and I think I did already grant it.

1 MS. RAMEAU: I thought that was already handled,  
2 Judge.

3 THE COURT: I think it was, but I think Mr. Ninosky  
4 just wants to be clear.

5 MR. NINOSKY: Well, and here's my confusion. They  
6 have asked that I produce Sarah Hardy tomorrow to testify. The  
7 only thing that Sarah Hardy did in this case was get -- when he  
8 came back from the hospital after the original surgery, got  
9 orders, and then later on that evening shipped him out because  
10 he had an infection. And the only reason that Liz Garcia is  
11 sitting here is because she did one dressing change. And, yet,  
12 Plaintiffs will not voluntarily dismiss the case as to her. So  
13 I'm confused as to why we're bringing in a nurse to talk about  
14 the only thing she did was get orders when he came back into the  
15 jail and then send him out when it had obvious signs of  
16 infection. And I have another nurse sitting here who did  
17 nothing other than one dressing change at the explicit direction  
18 of a doctor.

19 THE COURT: And I have no problem with the evidence of  
20 what suffering he underwent after the surgery if that comes in,  
21 but that is not part of the argument that there was any  
22 negligence with respect to the wound care or certainly that  
23 there was any deliberate indifference with respect to the wound  
24 care.

25 MR. SALEEM: Well, I would disagree, Your Honor, with

1 the last point. I do think there was deliberate indifference as  
2 to the wound care because in the medical records it's clearly  
3 stated that there was a period of time that when Plaintiff's  
4 dressing was changed Ms. Garcia was changing the dressing and  
5 she was starting to see what the wound looked like and the wound  
6 was open.

7           It wasn't even -- the dressing was not even there.  
8 And she took no further steps except to put some note in the  
9 documentation. Didn't inform anybody else, her other providers,  
10 took no additional steps. Just changed the dressing. Nine  
11 hours later was when Plaintiff started to desaturate and then  
12 ultimately led him to have to go back to the hospital. And so I  
13 think under indifference component, that's why she's in this  
14 case, Your Honor.

15           MR. NINOSKY: First of all, that's wrong. She changed  
16 a dressing and put a new one on. So just factually that's just  
17 not correct, but --

18           MR. SALEEM: No, that's not what I said, Your Honor.  
19 Just I want to be clear about this. She said that when she  
20 changed the dressing there was no prior dressing on it and that  
21 she put on her own dressing. I never said that she didn't put  
22 on a dressing, but there's a period of time where there is no  
23 dressing on, which needs to be addressed, because there's  
24 deliberate indifference here as to why a person is coming into a  
25 prison, coming after a surgery, an open appendectomy, and being

1 allowed to have his wound just be open without any covering on  
2 it, dressing on it.

3 MR. NINOSKY: And again, and that's not accurate. The  
4 dressing was changed. The documentation in the chart is clear.  
5 It was changed, okay. And irrespective, then they need a doctor  
6 to say, yes, the wound should have been covered or the dressing  
7 change was inadequate for some reason. You just don't speculate  
8 as to those types of issues. No one is tying in anything.  
9 Nobody says one word about dressing changes. Nobody says one  
10 word about dressing changes causing infection.

11 So that's one. And two, what she did was at the  
12 direct order of a physician, so she can't be deliberately  
13 indifferent as I think we're going to find under the Pearson  
14 case and nobody says she violated the standard of care because  
15 everything that we've heard about the violation of the standard  
16 of care is in this report. It ends when he goes to the  
17 hospital. It doesn't say anything about when he comes back. So  
18 she couldn't possibly have been under the PrimeCare staff that  
19 were negligent because she's not doing any of the pre-hospital  
20 care.

21 THE COURT: And the --

22 MR. NINOSKY: So that's why I don't even understand  
23 why she's here.

24 THE COURT: Attorney Saleem, I believe when the  
25 Plaintiffs agreed that post-surgery wound care was not in this

1 case, and part of it was because no expert suggested that there  
2 was a deviation from the standard of care or that anything was  
3 done improperly, much less deliberate indifference to the care  
4 of the prisoner. So there was no medical testimony to support  
5 that there was anything done improperly.

6 And I believe, Attorney Rameau, you indicated you  
7 wanted that to come in, the suffering he underwent during that  
8 period of time post-surgery because it was related to the  
9 negligence and/or deliberate indifference that occurred prior to  
10 his appendix bursting and being sent to the hospital in the  
11 first place.

12 So what you just said, Attorney Saleem, is  
13 inconsistent with that because now you're suggesting there's  
14 another theory of liability that has to do with care post-  
15 surgery. And I believe it's already been conceded by the  
16 Plaintiff that, no, post-surgery care is not an issue in this  
17 case for purposes of negligence or deliberate indifference. So  
18 I kind of need to know what it is. And I can tell you right  
19 now, if you have no expert to say that the care deviated from  
20 the accepted standard of care, there's no possible way you would  
21 be able to introduce any evidence to suggest that a failure on  
22 the part of the Defendants led to the infection that led to the  
23 second operation.

24 MS. RAMEAU: Your Honor, we'll dismiss the case  
25 against Ms. Garcia.

1 THE COURT: Okay. Well, that's -- that wasn't exactly  
2 what I was asking, but does that -- are you also conceding that  
3 you have no expert to say that the nurses did anything wrong  
4 after the surgery? That this case is about failure to diagnose  
5 this appendectomy and get him to the hospital in a timely  
6 fashion, but that that suffering he underwent after the surgery  
7 including having another surgery, an infection, et cetera, that  
8 all goes towards his damages in trying to determine the pain and  
9 suffering if the liability is found?

10 MS. RAMEAU: Yes, Your Honor.

11 THE COURT: Okay. Then that motion in limine, I think  
12 it's being reaffirmed because I believe you had previously  
13 conceded that point. And you still wish to dismiss with  
14 prejudice the claims against Elizabeth Garcia?

15 MS. RAMEAU: Yes, Your Honor.

16 THE COURT: All right. And there's no objection from  
17 the Defense?

18 MR. NINOSKY: Certainly not, Your Honor. Is there  
19 going to be a need for any testimony from Sarah Hardy now?

20 MR. SALEEM: One second.

21 MR. NINOSKY: I apologize for taking the jury's time,  
22 but I think it's good we're clearing this up now, Your Honor.

23 THE COURT: I agree. And I also don't like the jury  
24 being left to sit in the jury deliberation room, but I'm sure --  
25 which one is Nurse Garcia? At least you just got out of the

1 case.

2 MR. SALEEM: I just think that for Ms. Hardy, she can  
3 just describe just the process. She's a nurse. We can just  
4 call her as a witness just in terms of describing the process in  
5 terms of changing the wounds. Not necessarily -- just the  
6 experience of what's involved.

7 THE COURT: And that may go towards his pain and  
8 suffering?

9 MR. SALEEM: Yes.

10 THE COURT: Okay. Then I think the answer, Mr.  
11 Ninosky, is that -- does she have to come a far distance or is  
12 she --

13 MR. NINOSKY: Yes. She's going to be coming from  
14 Reading.

15 THE COURT: Okay. But if --

16 MR. NINOSKY: Well, it isn't exactly the end of the  
17 world, but I mean she'll be here, but I just wanted an offer of  
18 proof and if it's going to be limited to describe how the wound  
19 dressing changes were, that's fine.

20 MS. RAMEAU: And to her observations, of course --

21 THE COURT: Of the pains --

22 MS. RAMEAU: -- of what his wound looked like.

23 THE COURT: Right.

24 MS. RAMEAU: I mean, this is your offer of proof,  
25 right, Your Honor? This is sufficient.

1 THE COURT: Right.

2 MS. RAMEAU: Thank you.

3 THE COURT: No, certainly. I believe you are entitled  
4 to introduce all the suffering that was directly related to  
5 what's the alleged negligence and alleged reckless indifference.  
6 I say reckless indifference -- deliberate indifference.

7 All right. Before I bring the jury back and bring the  
8 witness back onto the witness stand, Mr. Saleem, do you have a  
9 pretty good idea of some direction for me as to what I interpret  
10 they report as saying and where you can go with this doctor as  
11 it pertains to the report?

12 MR. SALEEM: Yes, I do, Your Honor.

13 THE COURT: All right. Let's bring the doctor in  
14 first.

15 MR. NINOSKY: Curative instruction, please.

16 THE COURT: And I'll give the curative instruction on  
17 the blood.

18 MR. NINOSKY: Oh, and one other thing. There's a  
19 reference in the report to competent. "A competent medical  
20 professional would have." I don't think that that language is -  
21 -

22 THE COURT: Well, there are a couple of things at the  
23 end that are objectionable that he would never be allowed to  
24 testify to.

25 MR. NINOSKY: I just wanted to make sure that there is

1 not going to be any reference to somebody being incompetent. He  
2 can certainly there was a violation of standard care, but  
3 incompetent is a totally different connotation and isn't really  
4 covered under --

5 THE COURT: And recognizing that he's not a lawyer,  
6 but the word incompetence is not appropriate and I don't think  
7 you're going to bring this out anyway, that he was a victim of  
8 medical malpractice. Obviously, that's why he's testifying.  
9 The jury will ultimately determine. He just needs to determine  
10 whether it fell below the standard of care. That's how he says  
11 it was malpractice.

12 All right. Let's first bring the witness back in if  
13 we could have --

14 MR. SALEEM: Yes. Before we do that, yeah, I was  
15 concerned obviously in terms of the time, Your Honor. I mean, I  
16 don't have -- just if we could find out the witness'  
17 availability in the event that we don't finish him today.  
18 That's what (inaudible). We hadn't anticipated him going  
19 beyond.

20 THE COURT: Yeah. Let's bring him in and see what he  
21 says about that.

22 (Witness present)

23 THE COURT: Thank you very much, Doctor.

24 And, Doctor, there is an issue that has been raised  
25 about your availability, both through today and into tomorrow.

1 Do you have any availability?

2 THE WITNESS: No.

3 THE COURT: So you would need to be completed today?

4 THE WITNESS: Yes.

5 THE COURT: Your testimony?

6 THE WITNESS: Yes.

7 THE COURT: Well, let's see what we can do along those  
8 lines.

9 MR. NINOSKY: And maybe -- can we have Ms. Garcia --  
10 can she leave? I mean, can we indicate that she's dismissed  
11 from -- let the jury know why she's not here and that that's why  
12 she's not here?

13 THE COURT: We'll be issuing a formal order on the  
14 docket, but I will say right now the claims against Elizabeth  
15 Garcia, LPN, are dismissed with prejudice without objection.  
16 And certainly, ma'am, if you're not needed as a witness, you're  
17 free to leave if you'd like to.

18 MR. NINOSKY: Yeah. And she is not.

19 MR. SALEEM: And just also, Your Honor, just in  
20 addition to that instruction that they're not supposed to take  
21 any speculation as to the cause of that or, you know, the basis  
22 of that --

23 THE COURT: Certainly.

24 MR. SALEEM: -- in terms of Plaintiff's case.

25 THE COURT: Certainly.

1 MR. NINOSKY: Thank you, Your Honor.

2 THE COURT: And, of course, if you would like to  
3 remain in the gallery, you are free to remain in the gallery,  
4 but if you would like to return back home, you can do that as  
5 well.

6 All right. You can have the jury brought in.

7 MR. SALEEM: How long are we planning on staying, Your  
8 Honor?

9 THE COURT: Well, we've got to get the doctor  
10 finished.

11 MR. SALEEM: Okay.

12 THE COURT: But the more you can focus on his real  
13 testimony about where he believes there was negligence, the  
14 better.

15 MR. SALEEM: Okay.

16 THE BAILIFF: All rise.

17 (Jury present)

18 THE COURT: You may be seated.

19 The Court is called to order. All parties previously  
20 present are once again present. The jury is present. The  
21 witness is on the witness stand.

22 Ladies and gentlemen, I apologize for that delay and  
23 we will try to ensure that another similar type of delay does  
24 not occur.

25 A few things I need to advise you of. First, you will

1 notice that Elizabeth Garcia, LPN, is no longer present at the  
2 Defense table. All claims against her have been dismissed and  
3 so she will not be participating in this trial any further.

4 Also, you earlier heard some information about a blood  
5 test. There was no suggestion that there was anything wrong  
6 when the blood test was taken in this case, so you should  
7 disregard all of that testimony regarding that blood test.

8 Are both Counsel satisfied with the instructions from  
9 the Court?

10 MR. NINOSKY: I am, Your Honor. Thank you.

11 THE COURT: And Mr. Saleem, that was satisfactory?

12 MR. SALEEM: Yes, Your Honor.

13 THE COURT: Very well. Counselor, you may proceed.

14 DIRECT EXAMINATION CONTINUED

15 BY MR. SALEEM:

16 Q Doctor, I think we were last talking just around the  
17 assessment or note that occurred on April 17th at around 13:35,  
18 which is 1:35, okay. And I think the next time the Plaintiff  
19 was assessed there is the note that's on 4/17 at 19:11. And in  
20 this assessment, what are the Plaintiff's complaints in this  
21 assessment?

22 A The patient was complaining of abdominal pain.

23 Q Okay. And there's an indication that the PRN meds, which  
24 are the meds that he was supposed to be given as needed, that he  
25 -- what does he indicate that with respect to those meds?

1 A Patient was asked which PRN meds he wanted and replied,  
2 "None. They don't work anyway."

3 Q And the fact that it says he was agitated, what in  
4 conjunction with the fact that he didn't want the meds, is the  
5 significance of that?

6 A The fact that he feels he's not getting better.

7 Q Okay.

8 A And that the meds are not helping him get better.

9 Q Okay. And he's at this point still in the jail at this  
10 point.

11 A Correct.

12 Q Okay. And does the continuation of that note which  
13 continues on the next page and it says -- what does it state  
14 with respect to where the pain is going with the patient?

15 A "Patient is now stating the pain is going lower."

16 Q And what significance is the fact that the pain is going  
17 lower mean?

18 A It's starting to localize.

19 Q And when you say -- and just remind us again what that  
20 means, the fact that it was localizing.

21 A Well, the natural history of appendicitis is that the  
22 patient presents with pain in the center portion of the abdomen  
23 and then as the inflammation progresses it starts to localize to  
24 one of the quadrants. And by going lower, it's starting to  
25 localize to at least the lower part of the abdomen.

1 Q And is that where the appendix is usually located?

2 A Yes, in the right lower abdomen.

3 Q Okay. So based upon this, would you say that there is an  
4 indication that the Plaintiff was, at least based upon his  
5 progressing symptoms, was showing signs of appendicitis?

6 A Correct.

7 Q Okay. And his indication he would like to go to the  
8 hospital, what, if anything, does that signify to you?

9 A That means that he's getting worse.

10 Q Okay.

11 A And he's not getting better.

12 Q Okay. Okay. And based upon your assessment, would you  
13 have -- would it be a deviation to not send Plaintiff to the  
14 hospital at this point?

15 A Since an LPN is writing that note, my understanding of  
16 current medical practice would be to then notify the next level,  
17 a nurse practitioner or PA or a physician, to do a further  
18 assessment to either confirm or come up with a differential  
19 diagnosis or a plan to, you know, move the patient to the  
20 hospital. I, in my medical opinion, had I assessed the patient  
21 at that time, I would have thought that he needs a CT scan to  
22 rule out appendicitis.

23 Q Okay. And in this case Nurse Roberts conducted an  
24 assessment of him after making that entry where she notes  
25 essentially what we stated before, right, that the pain was in

1 the lower abdomen and that the patient was extremely agitated.

2 Do you see that?

3 A Yes.

4 Q Okay. And as a result of that assessment, there is a note  
5 in the record that she did speak to a provider in this case, Ms.  
6 Dillman-McGowan, and that's at PCM205. And as a result of this,  
7 it also notes in addition to what we just discussed, this also  
8 states that Plaintiff contains of testicular pain. What, if  
9 anything, do you make of that complaint?

10 A Well, patients with appendicitis can occasionally complain  
11 of testicular pain or pain down in the lower quadrants.

12 Q Okay. And can female nurses conduct testicular exams on  
13 male patients?

14 A They can, but an actual physical examination, nurses can't  
15 diagnose.

16 Q But it doesn't matter the sex of the person? I mean, can  
17 female doctors examine, do testicular exams of male patients?

18 A Yes. Yes.

19 MR. NINOSKY: Objection as to relevance.

20 THE COURT: I'll overrule it.

21 MR. NINOSKY: Okay.

22 BY MR. SALEEM:

23 Q Okay. So just the mere fact that the Plaintiff was a male  
24 and the nurse is a female is not really an issue in terms of  
25 being able to conduct an examination?

1 A No.

2 Q Okay. And what was -- as a result of getting this order,  
3 what was -- did Ms. McGowan send the Plaintiff to a hospital?

4 A No.

5 Q Did she order the Plaintiff to be going to a CT scan?

6 A No.

7 Q Okay. What did she do? Did she move him to another unit  
8 in the hospital? I mean, in the jail?

9 A The orders received say, "Moved to N unit."

10 Q Okay. And then also does it indicate -- and it indicated  
11 that she is going to be seeing him on Monday for the last entry?  
12 She's a provider.

13 A Right. Provider line 1, day 4/20.

14 Q Okay. So on April 17th someone who -- now, at this point  
15 Mr. Rodriguez had been complaining of abdominal pain at least  
16 four days, at least from the 14th. And now we're dealing with -  
17 - we're talking about the 17th. And she's going to decide that  
18 she's going to make an assessment on Monday, three days later.

19 A Correct.

20 Q Would you say that the failure to assess him --

21 THE COURT: The objection is going to be leading.

22 MR. NINOSKY: Objection.

23 THE COURT: Leading?

24 MR. NINOSKY: Leading and also --

25 THE COURT: I'll sustain the leading objection.

1 MR. NINOSKY: Okay.

2 MR. SALEEM: Okay.

3 THE COURT: So you may proceed.

4 BY MR. SALEEM:

5 Q Would it deviate from the standard of care to not to have  
6 until Monday to assess Mr. Rodriguez?

7 MR. NINOSKY: Objection. Violation of Court order.

8 THE COURT: That's overruled and I'll allow him to  
9 answer the question.

10 THE WITNESS: Yes. Reasonable medical treatment of a  
11 patient suffering from abdominal pain for three to four days  
12 that is not improving and is getting worse should be physically  
13 assessed by a health practitioner, either a PA, a nurse  
14 practitioner, or a physician. And three days after the initial  
15 three to four days of the complaint is too long of a period and  
16 deviates from the standard medical practice.

17 BY MR. SALEEM:

18 Q Thank you, Doctor. And chart notes are notes when any  
19 medical personnel -- what are chart notes? Sorry.

20 A Chart notes are a variety of different types of notes  
21 depending upon the practitioner charting the note.

22 Q Okay. And we were just discussing the April 17th at 19:11  
23 where the Plaintiff was extremely agitated. What is the date of  
24 the next entry of a note?

25 A April 20th at 8:00 a.m. in the morning.

1 Q Okay. So there are no chart notes for April 18th, is that  
2 correct?

3 A Correct.

4 Q Are there any chart notes for April 19th?

5 A No.

6 Q Okay. In your review of the chart, did you see any  
7 abdominal assessments conducted on the Plaintiff on April 18th?

8 A No.

9 Q Did you see any abdominal assessments conducted on the  
10 Plaintiff on April 19th?

11 A No.

12 Q Okay. What, if any, significance is there of the fact that  
13 Plaintiff's vital signs were taken on those two days?

14 A It's a minimal significance.

15 Q Why?

16 A Because it's not an adequate assessment. They can be  
17 altered, but they can also be normal.

18 Q Okay. Okay. One second, Your Honor.

19 THE COURT: Certainly, sir.

20 BY MR. SALEEM:

21 Q We have so many pages. One second. Sorry. Okay. Doctor,  
22 let's see.

23 MS. RAMEAU: Your Honor, may I?

24 THE COURT: Mr. Saleem, I believe Attorney Rameau may  
25 have what you're looking for.

1 MR. SALEEM: No, I'm not trying to, not yet.

2 MR. NINOSKY: I want to see.

3 BY MR. SALEEM:

4 Q Oh, sorry. Okay. And, Doctor, I want to show you now  
5 what's been marked as PCM215 which is -- indicates -- I just  
6 want to direct your attention. This is on PCM215, part of  
7 Plaintiff's 2. The entry on 4/20/2015 at 10:50 a.m. And  
8 there's a -- or is there anything significant about the vital  
9 signs?

10 A No.

11 Q Okay. But there are some notes here. What do the notes  
12 indicate?

13 A When approached patient had abdominal pain.

14 Q Well, before that what does it say regarding the patient?

15 A "Patient screaming on N unit."

16 Q Okay.

17 A "When approached, patient had abdominal pain."

18 Q Okay. And then after that it indicates that Ms. Dillman-  
19 McGowan was made aware of this.

20 A Aware of vital signs taken.

21 Q Okay. And what, if anything, do you make of the fact that  
22 Plaintiff was found to be screaming when approached?

23 A That he was in abdominal pain.

24 Q Okay.

25 A Significant abdominal pain.

1 Q Significant enough to be screaming.

2 A Yes.

3 Q Okay. And this is, again, on the 20th.

4 A Yes.

5 Q Okay. Great. Is there any indication in the chart or  
6 anywhere that he was not experiencing any type of pain on the  
7 18th or 19th?

8 A Not that I saw.

9 Q Okay. And that's because there are no assessments one way  
10 or the other, is that right?

11 A Correct.

12 Q Okay. Let me show you what's been marked as Plaintiff's  
13 143. This is a documentation -- this is the way it was printed  
14 out. It seems to be that some of the wording bleeds into the  
15 other, but it's an assessment conducted by Ms. McGowan on the  
16 20th. We initially mentioned the last record was about 10:50  
17 a.m. What time does this indicate that this record is?

18 A 11:16.

19 Q Okay. And this is -- according to the record, this is the  
20 first time Ms. McGowan has ever conducted an examination of the  
21 -- assessment of the patient.

22 A Correct.

23 Q There's no indication anywhere else that she conducted any  
24 kind of prior examination of the Plaintiff, correct?

25 A Not that I could find.

1 Q Okay. And what did she note as a result of her assessment?

2 A Abdominal pain, follow up labs, seen for above. Complains  
3 of abdominal pain over past two to three days.

4 Q Two to -- when you say two to three days, that would -- if  
5 we're looking at this, this is written on 4/20.

6 A Correct.

7 Q Two to three days would be how long ago? This would be the  
8 17th or the 18th, at least just two to three days.

9 A Right. The 17th or 18th.

10 Q Right. Okay. And we previously discussed that Mr.  
11 Rodriguez was complaining of pain on the 15th, right?

12 A Correct.

13 Q Because he spoke to the nurse on the 16th and said or the  
14 14th because she said past three days, right?

15 A Correct.

16 MR. NINOSKY: Objection. It's leading.

17 MR. SALEEM: Okay.

18 THE COURT: The objection is overruled, but I will  
19 caution, Mr. Saleem, with respect to the leading questions.

20 MR. SALEEM: That's fine, Your Honor.

21 BY MR. SALEEM:

22 Q And what is the significance of the fact that the pain is  
23 rated 10 out of the 0-10 scale?

24 A That it's significant pain.

25 Q It's high, okay.

1 A Very high.

2 Q And what does it indicate with respect to whether or not he  
3 is vomiting?

4 A It says, "Positive vomiting."

5 Q Okay. And what about respect to what makes the pain better  
6 or worse?

7 A Eating fruit improves pain. Drinking the milk makes pain  
8 worse.

9 Q And what, if anything, what significance do you place upon  
10 that?

11 A Not much.

12 Q Okay. And when does it indicate that the Plaintiff, Mr.  
13 Rodriguez, last vomited?

14 A Ten minutes ago.

15 Q Okay. And what about diarrhea?

16 A Diarrhea, last episode the day before.

17 Q Okay. And there's no indication of any assessment of  
18 anybody recognizing that he was having diarrhea the day before,  
19 is that right?

20 A No.

21 Q Okay. And okay. And what about looking at the objective  
22 test, what is indicated in the objective test?

23 A The skin is warm and dry, intact, good turgor, capillary  
24 refill, which is that you have a vascular supply. CV is  
25 cardiovascular. RRR means regular rate and rhythm, that the

1 heart is beating at a regular rate and rhythm. Respiratory,  
2 RESP, is your respiratory exam. And CTA stands for clear to  
3 auscultation. That means that when you listen to the lungs you  
4 don't hear any junk or other sounds in the lung. They appear  
5 clear.

6 Q And what, if anything, the significance of all those  
7 findings would be or good positive findings?

8 A Yes. They're normal. They're considered normal.

9 Q Okay.

10 A The abdominal time is soft, positive distention. So it's  
11 hard to be soft and distended at the same time. Absent bowel  
12 sounds.

13 Q So what does it mean that the fact that her exam noted him  
14 to be soft and distended?

15 A Well, they're sort of somewhat contradictory, but he was --  
16 you know, distended means that the abdomen is now sort of blown  
17 up, more distended.

18 Q Okay.

19 A And absent bowel sounds in all four quadrants means that  
20 the intestines have now stopped working.

21 Q Okay.

22 A And diffuse lower abdominal tenderness, no rebound.

23 Q And what significance is the fact that there's no rebound  
24 with all these other symptoms presenting?

25 A Well, not much.

1 Q Okay.

2 A It's not a very accurate sign, you know.

3 Q Okay. And the fact that there's no rebound tenderness,  
4 does that mean that you can discount that the Plaintiff was  
5 undergoing appendicitis?

6 A No.

7 Q Okay. And what is the assessment provided by Ms. Dillman-  
8 McGowan here?

9 A Abdominal pain, rule out obstruction.

10 Q And what is the significance of that note right there?

11 A Well, that means that he might -- that the assessment was  
12 that he had significant abdominal pain and that now the  
13 practitioner is thinking because he's distended, he has no bowel  
14 sounds, that he may have a bowel obstruction.

15 Q Okay. And based upon this assessment and what he was  
16 presenting with, would there be other potential diagnosis that  
17 he could be undergoing besides obstruction?

18 A Well, yes. I mean, he could have intraabdominal process.  
19 That's inflammation causing the intestines to shut down.

20 Q Okay. And does it indicate that she was suspecting  
21 appendicitis?

22 A No.

23 Q Okay. Based upon what was presented and based upon what  
24 was presented up until this point, would the diagnosis of  
25 appendicitis, the failure to diagnose appendicitis deviate from

1 the standard of care?

2 A No.

3 Q Okay. Why not?

4 A Because she made an assessment that the abdominal pain was  
5 severe and that he had an obstruction. And then she made the  
6 plan that he should be sent to the hospital.

7 Q Okay. And this is after seeing him only on the 20th.

8 A Correct.

9 Q Okay. Okay. Which was the first time she saw him.

10 A Correct.

11 Q Okay. And as a result of that, then she decided to send  
12 him to the emergency room.

13 A Correct.

14 Q Okay. Okay. And once Mr. Rodriguez was ultimately sent to  
15 the emergency room, that's at some point when he came into your  
16 care, is that correct?

17 A Correct.

18 Q Okay. And part of your assessment of him -- what was your  
19 plan once you saw Mr. Rodriguez for the first time?

20 A Well, the sequence of events is he was seen by the triage  
21 nurse and he was seen by the emergency room physician who felt  
22 he had an intraabdominal process going on.

23 Q And what do you mean by -- what does the term  
24 intraabdominal process mean?

25 A It's that he's sick. Something's going wrong in the

1 abdomen and he has sufficient abdominal pain to warrant a CT  
2 scan, whether he has appendicitis, which would be the most  
3 common diagnosis, whether he had some type of internal hernia.  
4 Diverticulitis would be not as common. Perforated ulcer could  
5 be common. You can get that even in your twenties. The ER  
6 doctor assessed him and said the next step is to get a CT scan.

7 Q Okay.

8 A Once they got the CT scan, it was clear that he had  
9 advanced perforated appendicitis with the findings of fluid  
10 around the appendix and the appendix being inflamed. And so the  
11 emergency room staff then notified the surgical team of which I  
12 was the doctor on call that Monday. My resident saw the  
13 patient, evaluated the patient, called me. I came and evaluated  
14 the patient and agreed with the diagnosis of perforated  
15 appendicitis. And my plan was to take the patient to the  
16 operating room for an appendectomy.

17 Q Okay. And were you planning on -- what type of  
18 appendectomy were you planning? Was it planning on being  
19 laparoscopic or were you planning on doing open appendectomy?

20 A My plan was to do a laparoscopic appendectomy.

21 Q And why was that your plan?

22 A Well, that's the best approach.

23 Q Okay. Doctor, I'm going to just show you what's been  
24 marked previously, referring to Plaintiff's Exhibit 3 in  
25 evidence, Reading Hospital records. I'm showing you Plaintiff's

1 -- Berks' -- sorry -- 1496. What is this document that I'm  
2 showing you?

3 A This is an operative note.

4 Q And an operation that you conducted?

5 A Yes.

6 Q On what day?

7 A 4/20/2015.

8 Q Okay. And what was the preoperative diagnosis?

9 A Acute perforated appendicitis.

10 Q Okay. And you maintained that -- what was the post-  
11 operative diagnosis?

12 A Acute perforated appendicitis with abscess and peritonitis.

13 Q And again, just remind the jury again what --

14 A So abscess is a pocket of puss and peritonitis means that  
15 the puss has spread throughout the abdomen.

16 Q And just again, referring to this document, again, the book  
17 that you referred to earlier, this *Atlas of Human Anatomy*, when  
18 you conducted your exam -- I'm just going to show you. So you  
19 went from a laparoscopic, which is using the camera, to open  
20 where you were actually able to see what was going on inside  
21 with your own eyes, is that right?

22 A Right. Well, I can see quite well with the laparoscope.

23 Q Right. Okay. I didn't mean to say that. So just looking  
24 at plate 261 of this document, when you said -- when you  
25 conducted the open appendectomy what -- can I approach, Your

1 Honor, for a second?

2 THE COURT: Certainly, Counselor.

3 BY MR. SALEEM:

4 Q Doctor, I'm just going to show you three different pages.  
5 And just tell me which the best would you describe in terms of  
6 what you saw or would you help the jury in terms of what you saw  
7 in terms of when you did the open appendectomy.

8 A This is fine.

9 Q Okay.

10 A Okay.

11 Q So just -- I'm referring again to what was previously show  
12 to jurors, plate 275. When you conducted the open appendectomy,  
13 what did you see?

14 A Okay. I put in the cannula at the belly button. And as  
15 soon as I made an incision in the belly button down through the  
16 skin, through the fat, and into the fascia, which gets into the  
17 abdomen, green fluid was coming up, very much similar to fluid  
18 you would vomit. It just poured out.

19 Q Would that be a finding that you would expect to find when  
20 you're conducting that kind of surgery?

21 A Only on an advanced appendicitis, late stages of  
22 appendicitis.

23 Q And when you say late stage of appendicitis, how long would  
24 it take for that to manifest itself to be able to see that kind  
25 of substance you're seeing?

1 MR. NINOSKY: Objection. Outside the scope and  
2 speculation.

3 THE COURT: I'm going to have to sustain that  
4 objection.

5 BY MR. SALEEM:

6 Q So what was it again? So when you saw it, where was this  
7 liquid or this green substance?

8 A The fluid was coming out of the umbilicus and the incision  
9 is small. It's only about the size of your thumb. And then I  
10 put the cannula in in order to put the TV camera in. When I put  
11 the TV camera in, I could see the green fluid and puss  
12 throughout the abdomen.

13 Q All right. And what did you do as a result of seeing that?

14 A Okay. It was my decision at that point that it would be  
15 more appropriate to open the patient to not only remove the  
16 appendix, but to significantly wash out the abdomen.

17 Q And why did you deem it more appropriate to do that as  
18 opposed to doing the procedure laparoscopically?

19 A Well, you can -- it was so contaminated that you needed  
20 liters and liters of fluid to try to get it clean and to get the  
21 puss off of the small intestines. And you need to get up all  
22 the quadrants, up near the spleen, up above the liver, under the  
23 liver, or else he will get abscesses and he won't get better.

24 Q And, doctor, when you said that you have conducted about  
25 hundreds of these appendectomies, is that fair to say?

1 A Yes.

2 Q And how would this, what you saw with respect to Mr.  
3 Rodriguez, compare to the ones that you've performed?

4 A This is one of the worst. You know, within the top ten out  
5 of a couple of hundred appendectomies as to how bad this  
6 appendicitis was.

7 Q Okay. And after the -- and at some point would you  
8 ultimately remove the appendix?

9 A Correct.

10 Q Okay. And is the appendix then sent for a pathology  
11 report?

12 A It is.

13 Q Okay. And I'm just going to show what's been previously  
14 marked as, I think it's Plaintiff's Exhibit 4, which is a  
15 surgical pathology report. Bates numbers 645 through 649. I'm  
16 showing the witness and the jury 648. And what is the purpose  
17 of sending the specimen for a pathology report?

18 A So that the pathologist -- when I look at the specimen and  
19 make what's called a clinical diagnosis. We send it to the  
20 pathology which then evaluates it and makes a diagnosis under  
21 the microscope for appendicitis. Most often it's acute  
22 appendicitis or inflammatory appendicitis, but in rare cases  
23 there could be tumors of the appendix.

24 Q So someone else, another doctor, is reviewing this?

25 A Yes. Right.

1 Q Is another doctor reviewing this to make an assessment?

2 A Yes. Another doctor. Uh-huh.

3 Q Sorry.

4 A Yes.

5 Q Not you, okay.

6 A No.

7 Q And what was the final diagnosis? What did the gross  
8 description of the appendix reveal based upon this pathology  
9 report?

10 A Specimen was retrieved, labeled appendix. Consists of an  
11 apparent ruptured ramiform -- just means wormlike. That's the  
12 appendix. Appendix arriving in two pieces because the appendix  
13 was actually necrotic or rotten that broke into pieces.

14 Q Did you break it or --

15 A No. It was already broken in pieces. The cirrhosa was  
16 shaggy, inflamed, with grey-green fibrinopurulent exudate.  
17 That's puss on the appendix. They talked about the lumen,  
18 partially filled lumen on the appendix. No definite fecalith.  
19 Fecalith is a little stool ball that can get stuck at the base  
20 of the appendix. And the final diagnosis was perforated acute  
21 appendicitis with periappendiceal phlegmon. Phlegmon means the  
22 same thing as an abscess, puss surrounding the appendix.

23 Q Okay. And how long did -- do you recall how long it took  
24 you to perform this surgery?

25 A No. An hour, hour and a half.

1 Q Okay. And as a result of having undergone this type of  
2 surgery, this open appendectomy, what are the likelihood or  
3 chances of a person developing an infection?

4 A Well, he had an infection.

5 Q Okay.

6 A And so when we went in and I decided I need to open, I  
7 opened. I took the appendix out. I washed out all four  
8 quadrants. Whenever we have contamination, especially in more  
9 than one quadrant, I use at least 10 liters of fluid. So you  
10 know what a 2 liter bottle of soda is. I'm using at least 10  
11 liters to wash it out until I get the fluid in the abdomen as  
12 clean as possible, as clear fluid. I aspirate out the fluid. I  
13 put a drain in. You can close the muscle layer, but you leave  
14 the skin wide open because otherwise he'd get an infection in  
15 the abdominal wall. And I packed that with betadine soaked  
16 gauze.

17 Q Okay. And how long does the patient have to have that  
18 wound be dressed or contained like that?

19 A I would think it would take four to six weeks to heal.

20 Q So, and how is it covered? You said four to six weeks.  
21 How is it covered during that time?

22 A Well, usually we use wet-to-dry dressings and we leave it  
23 wide open, so it's a packed wound. And every day it will slowly  
24 close and then it eventually just closes.

25 Q And there's something also called a wound vac. Do you know

1 what a wound vac is?

2 A A wound vac is a sponge we put in the wound and then we put  
3 a plastic tape over the wound so it creates a suction. And then  
4 we hook it to a little machine and it sucks on the wound, sucks  
5 the fluid out of the wound. By but sucking on the wound  
6 continuously, we get healing a little bit faster.

7 Q Okay. And as a result of this, Mr. Rodriguez having to  
8 undergo this open appendectomy, did his wound become infected  
9 again requiring him another hospitalization?

10 MR. NINOSKY: Objection.

11 THE COURT: Basis.

12 MR. NINOSKY: I mean, form of the question, how it was  
13 phrased.

14 THE COURT: Well, I guess the issue is it's not in the  
15 report that this occurred, but is this just to set forth what  
16 happened afterwards?

17 MR. SALEEM: Yes, Your Honor. Just --

18 THE COURT: All right. The form you're concerned with  
19 is what caused the infection.

20 MR. NINOSKY: Correct.

21 THE COURT: To the extent the question is just did he  
22 have an infection afterwards, I will prevent that question.

23 MR. NINOSKY: And, frankly, we can stipulate to that.

24 THE COURT: Very well. Stipulated that he did get an  
25 infection.

1           And Mr. Saleem, in all fairness to Mr. Ninosky, my  
2 understanding is your witness is not available tomorrow.

3           MR. SALEEM: Correct.

4           THE COURT: And we're running out of time for cross-  
5 examination.

6           MR. SALEEM: Correct.

7           THE COURT: And I certainly can't leave him no time  
8 for cross-examination.

9           MR. SALEEM: I understand that, Your Honor.

10          THE COURT: So the quicker you can wrap up, the  
11 better.

12          MR. SALEEM: I am trying to do that, yes.

13 BY MR. SALEEM:

14 Q       And just to show you, earlier when you saw the whole green  
15 puss and everything else on the abdomen, can you point out where  
16 in what regions you saw it?

17 A       Well, the majority of the puss is going to be in the lower  
18 abdomen just based on gravity, but there was puss up over the  
19 spleen, which is all the way up in the left upper quadrant and  
20 up over the liver.

21 Q       And the fact that you saw that, what, if anything, what is  
22 the significance of the finding of the puss all the way up  
23 there?

24 A       Well, the fact that it's been going on for a while. You  
25 know, in my estimation, greater than 24 hours.

1 MR. NINOSKY: Objection.

2 THE COURT: Outside the scope of the report?

3 MR. NINOSKY: Correct.

4 THE COURT: I'll overrule the objection.

5 MR. NINOSKY: Understood.

6 BY MR. SALEEM:

7 Q Continue.

8 A Can you ask the question again?

9 Q Sure. And just what is the significance of the fact that  
10 you saw the puss and other liquid and fluid up in those upper  
11 regions?

12 A That it's, one, that it takes a while to get that way. And  
13 the second thing is that it puts you at a very, very high risk  
14 for postoperative infection in that even washing out the abdomen  
15 doing the best we can we still get 20 percent infection abscess  
16 formation after we do that.

17 Q Okay. And did Mr. Rodriguez undergo another operation by  
18 you?

19 A Yes. He had to undergo a second washout procedure.

20 Q Okay. And as a result of that second washout, how long was  
21 his hospital stay after that washout?

22 A It's two months or so.

23 Q Okay. And so this incident -- and if I just show you that  
24 the record shows -- if I say June 3rd, would you disagree with  
25 that?

1 A No.

2 Q Okay. But is it fair to say you continued to treat with  
3 him up until and including August 7th?

4 A Yes. I saw him out of the hospital in my office at patient  
5 visits.

6 Q Okay. And as of -- and during the course of his hospital  
7 stay, what type of treatment was he getting?

8 A Well, he was getting antibiotic therapy and we had taken  
9 cultures. Cultures are where we grow out the bacteria to see  
10 what type of bacteria he has so that we can narrow our  
11 antibiotics to specifically treat the bacteria that was causing  
12 the problem. He also needed to be anticoagulated. Because of  
13 the degree of inflammation within the abdomen, he had developed  
14 a clot in the main vein of the intestines going up towards the  
15 liver. And so when you have a lot of inflammation in the  
16 abdomen the veins can clot off. And he had a clot in one of  
17 those veins. And so he needed to be anticoagulated, which means  
18 his blood needed to be thinned so that that clot didn't grow.  
19 The body will eventually absorb the clot. But while he was in  
20 the hospital we had him on Heparin, which is a medicine that  
21 thins the blood.

22 Q And if untreated, what could be the likely outcome of that  
23 blood clot?

24 MR. NINOSKY: Objection. Relevance.

25 THE COURT: Sustained.

1 BY MR. SALEEM:

2 Q Doctor, I'm just going to show you a note on July 6th. And  
3 there's an indication here that he had a tube in place in lower  
4 right quadrant.

5 A Correct.

6 Q What does that mean?

7 A After we had washed him out and then he was in the hospital  
8 and he came back because his wound wasn't looking good. He was  
9 sick. We opened him up, washed him out again, and he did well.  
10 And then he got worse again, but this time when we did CT scans  
11 the puss pocket was localized to the right lower quadrant. And  
12 so instead of re-operating on him, which every time you re-  
13 operate the risks go up for having some other problem,  
14 interventional radiologists stuck a tube in his right abdomen in  
15 the vicinity of where the appendix used to be and was draining  
16 the puss. So he had a tube that had to stay in until the puss  
17 was completely drained.

18 Q And your surgery, the second surgery was on April 27, 2015?

19 A Correct.

20 Q And he was still having that tube as of July 6, 2015?

21 A He had to keep it in for a long time.

22 Q Okay. And how does that -- is that just something that's  
23 literally like a bag that's -- what is that?

24 A It's a little tube about the size of a straw and it goes to  
25 a little -- we call it a grenade. It's about the size of a

1 potato. It's just a little collection device that puts a  
2 suction on it and it collects there and you change it twice a  
3 day, empty it twice a day.

4 Q Okay. Just give me one second, Your Honor, okay?

5 THE COURT: Certainly, Counselor.

6 MR. SALEEM: Thank you.

7 BY MR. SALEEM:

8 Q And, Doctor, while Mr. Rodriguez was in the hospital was he  
9 also getting antibiotics?

10 A He was getting IV antibiotics.

11 Q And what does it mean, IV antibiotics?

12 A Well, there's two ways to administer it. IV, which goes  
13 into a vein, or with pills. The type of infection he had was  
14 best managed with the IV antibiotics.

15 Q Okay. So there was literally a line in his arms.

16 A Correct.

17 Q Okay. And he had that line in his arms for several weeks.

18 A Yes.

19 Q Okay. And, Doctor, do you have an opinion within a  
20 reasonable degree of medical certainty that the delay in sending  
21 Mr. Rodriguez to the hospital from the jail deviated or breached  
22 the standard of care in the profession?

23 A I do.

24 Q Okay. And what is that opinion?

25 A My opinion is that there was a breach in the standard

1 medical care and that he should have been more vigorously  
2 evaluated and sent to the hospital sooner.

3 Q Okay. And do you have an opinion of the degree of medical  
4 certainty as to the standard of care provided to him by the LPNs  
5 and the RNs who are seeing Mr. Rodriguez prior to him going to  
6 the hospital?

7 A I do.

8 Q And what is that opinion?

9 A That he should have been physically assessed by a  
10 practitioner sooner. And my opinion is that he should have been  
11 assessed on Friday by a nurse practitioner, a PA, or a  
12 physician.

13 Q Okay. And do you have an opinion with a reasonable degree  
14 of medical certainty as to whether the delay in sending him to  
15 the hospital was a contributing factor in him needing the open  
16 appendectomy?

17 A Yes.

18 Q What is that?

19 A Yes. That the delay contributed to him having to have an  
20 open appendectomy as opposed to a laparoscopic appendectomy.

21 Q And along with that open appendectomy, the fact that he had  
22 to go into an additional surgery performed by you.

23 A Correct.

24 Q Okay. IN addition to the hospital, of course, that lasted  
25 through June 3rd.

1 A Correct.

2 Q Okay. And during that course of time he also -- the  
3 medical records indicate that he experienced bouts of nausea.

4 A Correct.

5 Q Do they indicate that he experienced bouts of vomiting?

6 A Yes.

7 Q Did it indicate that he experienced bouts of --

8 MR. NINOSKY: Objection.

9 THE COURT: It's leading.

10 BY MR. SALEEM:

11 Q Okay. Do you remember what other types of complaints that  
12 you mentioned that he underwent while he was in the hospital?

13 A Well, you can imagine with that degree of inflammation it  
14 will take a while for the intestines to come back and feel  
15 hungry again where you actually felt that you wanted to sit down  
16 and eat something, so he struggled with that. He had episodes  
17 of rapid heartrate with that infection in his system. He had an  
18 inflammatory response in his system that he had a rapid  
19 heartrate that had to be slowed down until the body and the  
20 antibiotics, you know, got ahead of the infection.

21 Q And was there any indication that Plaintiff experienced  
22 pain while he was in the hospital?

23 A Yes.

24 Q Okay.

25 A Yeah.

1 Q And what type of pain would one -- did he experience?

2 A Abdominal pain. He had a pretty good size incision and it  
3 hurts.

4 Q Okay. And how long would you expect -- was he experiencing  
5 that pain for?

6 A He was experiencing the pain for most of the  
7 hospitalization from either the wound, which then the pain  
8 quiets down, you know, weeks after the wound. And then pain  
9 from having the tube in your side which irritates the muscle.  
10 Every time you move around the tube pulls.

11 Q Okay. When you say every time you move around, so he could  
12 experience pain when? Anytime he moves?

13 A When he had the drain in, it gets a little bit  
14 uncomfortable.

15 Q Okay. One second.

16 THE COURT: We really need to hurry this along.

17 MR. SALEEM: Yes, I understand.

18 I have no further questions, Your Honor.

19 THE COURT: Thank you very much, Counselor.

20 Mr. Ninosky, you may cross-examine the witness.

21 MR. NINOSKY: Thank you, Your Honor.

22 CROSS-EXAMINATION

23 BY MR. NINOSKY:

24 Q Good afternoon, Doctor.

25 A Hi.

1 Q Doctor, I'm going to maybe start a little bit in reverse --

2 A Okay.

3 Q -- with the hospital course, first of all. When he came to  
4 the hospital, he probably came around 12:30 or so. Does that  
5 sound about right to you?

6 A Correct.

7 Q And he was evaluated by Dr. Sha (phonetic) in the emergency  
8 room, was he not, sir?

9 A Correct.

10 Q He's an emergency room physician, right?

11 A Correct.

12 Q And I know you kind of gave a little bit of a time frame  
13 for the jury, but I think skipped a couple of parts. When Dr.  
14 Sha did an assessment he felt that there could be a small bowel  
15 obstruction, correct?

16 A Correct.

17 Q And, in fact, he started his workup -- I shouldn't say  
18 started his workup, but because he had concerns of the small  
19 bowel obstruction which he came to on his own, right? I mean,  
20 that was his assessment.

21 A Correct.

22 Q That wasn't called ahead by Paula Dillman, right?

23 A I don't know, but I don't disagree with you. I'm not  
24 disagreeing with you.

25 Q Okay. So let's do it this way.

1 A Yes.

2 Q There's nothing in the record that indicates that.

3 A Correct.

4 Q That might be a more fair way of doing it.

5 A Fine.

6 Q And he ordered an x-ray, right?

7 A Yes.

8 Q He didn't order a CT scan. He ordered an x-ray.

9 A Correct.

10 Q So the first thing that he did, because he wanted to rule  
11 out a small bowel obstruction, was an x-ray.

12 A Correct.

13 Q It wasn't until he did a CT scan, that's when it was  
14 determined that he had the appendicitis, right?

15 A Correct.

16 Q Okay. So Dr. Sha was thinking small bowel obstruction just  
17 like Ms. Dillman-McGowan, correct?

18 A Correct.

19 Q And when he ordered the testing, the first test that he did  
20 kind of showed small bowel obstruction, right?

21 A Correct.

22 Q But ultimately he -- because he needed additional testing,  
23 that's when the appendicitis was revealed.

24 A Correct.

25 Q Okay. So it wasn't quite he just walked in, went right to

1 CT, and then to surgery. It took a little bit of time.

2 A Correct.

3 Q In fact, I think he came in around 12:30. I don't think he  
4 left the ED until 8:30-ish.

5 A Well --

6 Q And my guess is you're not even starting a procedure until  
7 after 9:00-ish. Does that sound about right to you?

8 A Correct. I saw him around 5:00 that night, a little bit  
9 after 5:00. The CT scan came back near 5:00.

10 Q And after that came back, then they knew they had a  
11 surgical situation --

12 A Correct.

13 Q -- and they needed to get you involved.

14 A Correct.

15 Q And you weren't involved until that time.

16 A Correct.

17 Q And generally speaking, somebody doesn't walk in off the  
18 street into your practice and say, "I've got belly pain. You've  
19 got to check me out." Generally speaking, there's other  
20 providers ahead of you.

21 A Correct.

22 Q Okay. So usually by the time you have an opportunity to  
23 examine a patient you have probably at least a little bit more  
24 time of a history, is that correct?

25 A Correct.

1 Q You might have diagnostic testing or not, correct?

2 A Correct.

3 Q And that diagnostic testing could be lab results.

4 A Correct.

5 Q Okay. Could be urine results.

6 A Correct.

7 Q Okay. Because I think you told us, you know, things -- you  
8 have to work things up and one way to do that is through  
9 diagnostic testing, right?

10 A That's one way.

11 Q Okay. Right. You do a history, fair?

12 A Correct.

13 Q Do a physical exam.

14 A Yes.

15 Q Okay. And you would agree with me that a lot of the  
16 symptoms that we're talking about in this particular case like  
17 nausea and vomiting, that could be a whole host of things that  
18 could cause nausea and vomiting, correct?

19 A Correct.

20 Q And I think way back this morning you had said about doing  
21 -- when you have a potential diagnosis you try to rule out the  
22 most serious thing first. Isn't it that you're trying to rule  
23 out the most common thing first, Doctor?

24 A Combination of both.

25 Q Because if I say to you right now I have abdominal pain, I

1 could have cancer, could I not?

2 A Sure.

3 Q But you're not going to just send me out for a pet scan to  
4 see if I have cancer just because I complain about abdominal  
5 pain.

6 A Correct.

7 Q Okay. And you would agree with me that sometimes the best  
8 test is just a little bit of time.

9 A Correct.

10 Q Especially when we're talking about symptoms such as nausea  
11 and vomiting. That can be pretty benign.

12 A Correct.

13 Q Okay. So you would -- and you told us that  
14 gastroenteritis, which is a fancy way of saying your stomach is  
15 upset and you're having some belly ache, right?

16 A Correct.

17 Q Okay. You told us that it's reasonable to have  
18 gastroenteritis as a result of Naproxen use.

19 A Correct.

20 Q Or that type of medication.

21 A Yes.

22 Q Okay. So that, to you, is a reasonable thought process.

23 A Yes. Uh-huh.

24 Q Okay. You also told us that, you know, you can have  
25 abdominal pain for a number of reasons, correct?

1 A Correct.

2 Q And we went through everything from gastroenteritis to  
3 appendicitis to I think you said gall bladder. There's a whole  
4 bunch of things.

5 A Yes.

6 Q Okay. So that's why it's important to, again, work through  
7 a process to figure out what's getting better, what's making it  
8 worse, that type of thing, right?

9 A Correct. Uh-huh.

10 Q Okay. And in this particular instance -- boy, that got  
11 loud, didn't it? Wow. In this particular case, I mean, you  
12 could see a thought process going on, can't you? I mean,  
13 there's an assessment. There's a call for orders. They're  
14 thinking about gastroenteritis, correct?

15 MR. SALEEM: Objection.

16 THE COURT: Basis?

17 MR. SALEEM: Unclear what the question is.

18 THE COURT: Would you re-ask the question, sir?

19 BY MR. NINOSKY:

20 Q Did you understand me?

21 A To a degree.

22 Q Okay. Well, then I want to make sure I'm clear for it. In  
23 this particular instance, you would agree that certainly when  
24 there was a complaint of abdominal pain the first time that it  
25 is documented is the 16th, correct?

1 A Correct.

2 Q And you said that based upon that note it was either the  
3 14th or the 15th, how it was written, correct?

4 A Correct.

5 Q Now, you didn't read Susan Roberts' deposition, but I  
6 represent to you that she said it would have been the 15th.

7 A Fine.

8 Q Okay. All right. And I don't think you're going to  
9 quibble about that. And I also think when you talked to him  
10 about a history he said four days, correct?

11 A Correct.

12 Q And that would have been back to the 16th.

13 A Fine.

14 Q So we're kind of right around that 16th-ish.

15 A Correct.

16 Q Fair enough?

17 A Correct.

18 Q Okay. By the way, I didn't see anything in your  
19 documentation about any difficulties in communicating with Mr.  
20 Rodriguez, correct?

21 A Correct.

22 Q You were able to get a history from him?

23 A Yes.

24 Q You didn't indicate that he had any sort of difficulties  
25 articulating what his symptoms were, correct?

1 A Correct.

2 Q From your view, he gave you a sufficient history.

3 A Yes.

4 Q Okay. And from your view, he understood what you were  
5 asking of him.

6 A Yes.

7 Q Okay. And I've reviewed PrimeCare records. I have  
8 reviewed records from other providers at Reading Hospital. I  
9 have reviewed records --

10 MR. SALEEM: Objection, Your Honor. Why is Mr.  
11 Ninosky testifying as to what he's been doing?

12 THE COURT: It's cross-examination now.

13 MR. SALEEM: I understand, but there's not a question  
14 there.

15 THE COURT: Okay. I'm going to overrule the objection  
16 and see if a question is going to come.

17 BY MR. NINOSKY:

18 Q I've got a stack of records over there about a foot high,  
19 both PrimeCare records, Reading Hospital records, St. Joseph's  
20 records, records from before he was in jail right up until when  
21 you discharged him. I don't see anywhere in those records of a  
22 person having difficulty talking with Mr. Rodriguez and him  
23 understanding the process to obtain medical care. I don't see  
24 anybody -- no healthcare provider has indicated that he didn't  
25 understand or wasn't able to participate in his care. Would you

1 agree with me on that?

2 A Yes.

3 Q Okay. So from your view, there's no issues with him being  
4 able to explain himself and what symptomology that he would have  
5 had, fair?

6 A When I talked to him, yes.

7 Q Sure. And at that point he was getting ready to go to  
8 surgery, right?

9 A Yes.

10 Q Okay. You would agree with me, and I think I saw it in  
11 your report, that an appendicitis can be a difficult thing to  
12 diagnose.

13 A Correct.

14 Q In fact, I think you said in your report that you've seen  
15 many cases of delayed diagnosis, correct?

16 A I have.

17 Q And just because there was a delay in the diagnosis, that  
18 doesn't mean there was malpractice every time, does it, sir?

19 A Correct. It does not mean that there has been malpractice.

20 Q Right. Because sometimes things just take a little time to  
21 get it boiled down to what the problem is, correct?

22 A Yes.

23 Q And in this particular case, you had said that there was a  
24 decline in his presentation in the jail, but there was  
25 documented vomiting in the late evening of Thursday into early

1 Friday, correct?

2 A Correct.

3 Q And then we went through the chart notes, and I'm not going  
4 to put them up because it's getting towards the end of the day,  
5 but you saw those chart notes where he was assessed by nurse in  
6 place during the day on Friday, correct?

7 A Correct.

8 Q And it indicated there had been no new vomiting, correct?

9 A No --

10 Q No emesis. I mean, I can dig it out if you like.

11 A No. I'll accept that, you know, that he may not have  
12 vomited.

13 Q During the day.

14 A During the day.

15 Q Okay. So it wasn't as if we had intractable vomiting, but  
16 rather he had vomited in the early morning hours or late evening  
17 and then we go a period of time where he wasn't vomiting.

18 A Correct.

19 Q Okay. And we know that at least he ate lunch, at least  
20 some of his lunch. I'm not saying he had a buffet, but he  
21 certainly was able to eat.

22 A No. I would disagree with that.

23 Q You would? So when it says that he was able to eat lunch,  
24 that's inaccurate?

25 A Can you show me? I don't --

1 Q Absolutely. It's going to be 73 and we're going to pull it  
2 out for you. And it's a note by Lauren Becker, sir. I'll tell  
3 you what. To move it along, I'm just going to bring it up to  
4 you. The jury has already seen this.

5 A Okay.

6 Q I don't want you to think I'm pulling a -- Your Honor, may  
7 I approach?

8 THE COURT: Oh, certainly, Counselor.

9 BY MR. NINOSKY:

10 Q Do you mind if I kind of invade your space?

11 A No, no, fine.

12 Q Okay. See the note by Lauren Becker, sir?

13 A Yes.

14 Q You see that she was assessed during -- that the patient  
15 was assessed twice during the day, fair?

16 A Right.

17 Q Said that he was feeling weak. I get it.

18 A Right.

19 Q Had no appetite, but reported no emesis since early  
20 morning.

21 A Correct.

22 Q Okay. His vital signs are stable.

23 A Correct.

24 Q No fever.

25 A Right.

1 Q He reported eating nothing for breakfast and a small amount  
2 for lunch, so he did eat for lunch.

3 A A small amount.

4 Q Fair. But that was more than he ate for breakfast, right?

5 A Correct.

6 Q So the fact that he isn't throwing up and the fact that  
7 he's actually increasing his food intake, that's a good thing,  
8 isn't it?

9 A I don't agree with your assessment that he didn't vomit.  
10 When somebody vomits, they usually vomit every six to eight  
11 hours. You fill up your stomach, then you vomit. And then you  
12 fill better after you vomit. And then the process goes on and  
13 six to eight hours you vomit again. And a small amount of  
14 lunch, you can call it lunch. I don't know if it was one sip  
15 and they're constituting it as lunch. So in my mind in total of  
16 the whole chart, he's not getting better.

17 Q So you're disagreeing with me because you're not exactly  
18 sure to the extent that he ate lunch.

19 A Correct.

20 Q And you're disagreeing with me because it's possible that  
21 you may go hours without vomiting, so the fact that he went 12,  
22 at least 12 hours at that point without vomiting, that may not  
23 be a sign of him getting better.

24 A Correct.

25 Q However, if you're sitting there real-time, would you agree

1 with me that it could be a sign that he's getting better?

2 A Yes.

3 Q Okay. And that's the tough part, isn't it, when we know  
4 the ultimate outcome and what the diagnosis was, but when you're  
5 looking at it from stages, you know, you would agree with me  
6 that it's reasonable to think that, yeah, that's an improvement,  
7 right?

8 A Yes.

9 Q Okay. And when you're treating real-time, I mean that's  
10 kind of what you're looking for, isn't it?

11 A Yes.

12 Q Okay. And I'm not going to go through all the pages or of  
13 the vital signs.

14 A Correct.

15 Q But you would agree with me that in the entire time up and  
16 through you doing his surgery his vital signs were taken a  
17 number of times at the Berks County Jail.

18 A Yes.

19 Q Okay. And at every one of those times the vital signs were  
20 within normal limits.

21 A There was one time where the heart rate was elevated or the  
22 heart rate was lower, but they were within a general range of  
23 normal.

24 Q And I think you told us that 56, the pulse that was a  
25 little low, that was also when he had complained about vomiting,

1 right?

2 A Correct.

3 Q Never saw another pulse that was that low, did you, Doctor?

4 A No.

5 Q Okay. And so there we have a documented instance of a low  
6 pulse during a time frame when he had vomiting and we don't have  
7 that low pulse again, do we?

8 A No.

9 Q And we also don't have documented anywhere else up until  
10 Paula Dillman seeing him, frankly ten minutes before she sees  
11 him, of any other complaints of vomiting, correct?

12 A Yeah. We have no documentation.

13 Q Well, we know that at times he would complain and there  
14 would be a response, correct? This whole thing started with him  
15 complaining of abdominal pain, right?

16 A Correct.

17 Q And we have gone -- we spent most of the day going through  
18 the response to that complaint, correct?

19 A Correct.

20 Q All right. And you would also agree with me and you were  
21 shown on the 20th in the morning when he had severe abdominal  
22 pain, which by the way, that was the only time it was documents  
23 in the Berks County Jail severe abdominal pain, correct?

24 A Correct.

25 Q And that was during a vital signs check, nothing special.

1 It was the same vital signs check that had been done twice on  
2 Saturday and twice on Sunday. Fair statement, sir?

3 A No. I don't believe that the assessment over the weekend  
4 rises to the level of standard medical care.

5 Q That's not what I'm asking you. What I'm saying to you is  
6 he had his vital signs checked twice on Saturday, no doubt about  
7 that.

8 A Correct. Correct.

9 Q He got his vital signs checked twice on Sunday. No doubt  
10 about that.

11 A Correct.

12 Q Okay. And that was done by registered nurses both times, I  
13 believe, but whatever.

14 A Okay. Fine. Fine.

15 Q A nurse. Now, on Monday morning his vital signs were  
16 checked again, this time by a medical assistant, right?

17 A Correct.

18 Q And at that point it was actually documented that he had a  
19 complaint. He was complaining of abdominal pain, right?

20 A Correct.

21 Q That was documented.

22 A Correct.

23 Q So we have documented situations where he complains that  
24 are in the record. Correct, sir?

25 A Correct.

1 Q But we also have a period of time where we don't have any  
2 complaints documented, correct?

3 A Correct.

4 Q Yet the same assessments that are going on by multiple  
5 people have no indication other than their normal vital signs  
6 and obviously there were no complaints articulated by the  
7 patient because there's nothing charted, correct?

8 A There was nothing charted.

9 Q You would agree with me that it's at least possible that  
10 the reason why there isn't any complaints charted is because he  
11 didn't make any.

12 MR. SALEEM: Objection. Calls for speculation.

13 THE COURT: It's overruled.

14 THE WITNESS: That is a possibility.

15 BY MR. NINOSKY:

16 Q Certainly. Because we know in other instances where  
17 there's complaints they are documented, right?

18 A Correct.

19 Q And you would expect that nurses, which by the way they  
20 weren't sued. So these people on Saturday and Sunday, they're  
21 not sued.

22 MR. SALEEM: Objection.

23 MR. NINOSKY: Okay.

24 MR. SALEEM: Argumentative.

25 MR. NINOSKY: I'm just trying to give a factual

1 predicate, Your Honor.

2 THE COURT: If the objection is argumentative, this is  
3 cross-examination. I'll overrule that objection.

4 BY MR. NINOSKY:

5 Q So the nurses that --

6 A They work for PrimeCare.

7 Q Sir, they weren't sued, okay. So they were never, in no  
8 document are they sued. Those nurses -- you would presume, sir,  
9 that if complaints were made to them that they would document  
10 it, right?

11 A Yes.

12 Q Just like the other instances when complaints were made  
13 there was documentation such as Suzy documented when there were  
14 complaints given to her, correct? You would expect that.

15 A Correct.

16 Q Okay. You would also expect that if they had complaints  
17 that they would report them to a provider, which is what  
18 happened in this particular case with Suzy and Allison Young,  
19 correct?

20 A Correct.

21 MR. SALEEM: Assumes facts not in evidence.

22 MR. NINOSKY: He's an expert. I mean --

23 THE COURT: The objection was it assumes facts not in  
24 evidence, but those facts are in evidence.

25 MR. SALEEM: Can we approach, Your Honor?

1 THE COURT: Certainly. Counsel, please approach.

2 (Sidebar)

3 MR. NINOSKY: I don't have much more.

4 MR. SALEEM: (Inaudible).

5 MS. RAMEAU: So he's asking him, right, to speculate  
6 as to whether -- the doctor has already testified that there was  
7 no proper assessment, okay. And my understanding of his  
8 testimony is that had there been an actual assessment that  
9 perhaps it would have yielded some sort of complaint or, you  
10 know, some change in the treatment plan. So now he's asking him  
11 to vouch for how accurate PrimeCare personnel documented.  
12 That's --

13 THE COURT: He said he can't (inaudible) because  
14 there's nothing there. That means (inaudible).

15 MR. NINOSKY: Right.

16 THE COURT: (Inaudible).

17 MR. NINOSKY: That's correct.

18 THE COURT: So (inaudible).

19 MS. RAMEAU: That's all right, Your Honor. We can  
20 move on.

21 THE COURT: All right. Thank you, Counsel.

22 (Sidebar)

23 THE COURT: Mr. Ninosky, you may proceed, sir.

24 MR. NINOSKY: Thank you, Your Honor.

25 BY MR. NINOSKY:

1 Q You had indicated the -- you performed your surgery and  
2 then you followed him for a couple of months, fair?

3 A Correct.

4 Q And you had seen the note there from July where he still  
5 had the drain, is that correct?

6 A Correct.

7 Q But he was ambulating well.

8 A Yes.

9 Q Eating whatever he wanted.

10 A Yes.

11 Q Basically resuming normal activities.

12 A Yes.

13 Q Okay. And then I think the last time you saw him was in  
14 August, fair?

15 A Correct.

16 Q And you discharged him.

17 A Correct.

18 Q Okay. He never came back to you.

19 A Correct.

20 Q So from your view he was resolved by, I think it was August  
21 7th.

22 A Yes.

23 Q Okay. Because there's no further treatment, you didn't  
24 bring him back, and he hasn't come back to you.

25 A Correct.

1 Q Okay. Sir, those are all the questions I have for you.

2 A Thank you.

3 Q Thank you.

4 THE COURT: Thank you very much, Mr. Ninosky.

5 Mr. Saleem, you may redirect the witness.

6 MS. RAMEAU: Can we brief, Your Honor, for just a  
7 moment?

8 THE COURT: Certainly, yes.

9 REDIRECT EXAMINATION

10 BY MR. SALEEM:

11 Q Doctor, what effect does a person's age or size bear on  
12 their vital signs?

13 A Once the patient reaches adulthood their vital signs should  
14 be the same.

15 Q Okay. And what, if any, significance is the fact that Mr.  
16 Rodriguez' vital signs remained in the normal range throughout  
17 the course of his time at Berks County?

18 A When a patient gets ill the vital signs can change, but  
19 they don't always change.

20 Q Okay.

21 A And a person who's larger can have an intraabdominal  
22 process where his vital signs may not change up until he becomes  
23 very ill. And so it's a variable piece of information. It  
24 helps you if they're abnormal to realize that something is going  
25 on, but if they're normal it doesn't rule out a process going on

1 within the abdomen.

2 Q Okay. And it was discussed that Mr. Rodriguez didn't make  
3 any -- there's no documentation of any complaints from Mr.  
4 Rodriguez on the 18th and 19th. Does the fact that there was no  
5 complaints, does that necessarily mean that he was fine and  
6 didn't have any complaints?

7 A No. The documentation on Saturday and Sunday is very poor  
8 and in looking back at those notes I can't tell whether he ever  
9 had an abdominal assessment other than there are no complaints  
10 there, whether the patient offered no complaints, whether the  
11 patient was feeling better, whether the patient was feeling  
12 worse, whether the patient was hungry, whether the patient was  
13 not hungry. You can't tell because the documentation is so poor  
14 on Saturday and Sunday that a reasonable practitioner could not  
15 look at that and say that an adequate assessment was done.

16 Q Okay. And the only basis that we would have -- evidence  
17 that we would have is if somebody had actually made a  
18 documentation of that in the chart, is that right?

19 A Correct.

20 Q Okay. And the extent of the -- your opinion with a  
21 reasonable degree of medical certainty as to the extent of the  
22 damage that you saw to Mr. Rodriguez' appendix was due to a  
23 delay in him being treated.

24 MR. NINOSKY: Objection.

25 THE COURT: It's outside the scope of the cross. It's

1 close enough.

2 MR. NINOSKY: Okay.

3 THE COURT: I'll allow it. I'll overrule the  
4 objection.

5 THE WITNESS: My findings on Monday at the time when I  
6 operated with a high degree of medical certainty that he had  
7 appendicitis going on for quite some time and definitely 24 to  
8 48 hours before he presented to the emergency room, and I  
9 suspect longer. You can't tell --

10 MR. NINOSKY: Objection. Move to strike. You already  
11 upon this, Your Honor, to preclude just that testimony.

12 MS. RAMEAU: Can we approach, Your Honor?

13 THE COURT: Certainly. Counsel, please approach.

14 (Sidebar)

15 MR. NINOSKY: The Court has already ruled that he  
16 cannot talk about the extent of the hours or the delay. It's  
17 noted in his report. You've already sustained one objection as  
18 to that very question. Now he just -- frankly, Your Honor, he  
19 knows the issues in the case as to what's in the report, which  
20 isn't in the report, and now he's going to volunteer that in  
21 response to Counsel's question. I would ask that the witness be  
22 cautioned to only answer questions that are directed to him as  
23 opposed to going off the reservation giving stuff that you've  
24 already ruled out.

25 MS. RAMEAU: But wait a minute, Your Honor. Okay.

1 Let's be reasonable here because you are trying to get this jury  
2 to think that given the extent of this man's disease that he was  
3 perfectly fine on the 18th and the 19th, right? So you opened  
4 the door. That's what I think. You opened the door.

5 MR. NINOSKY: I don't think so, Your Honor.

6 MS. RAMEAU: I beg to differ.

7 MR. NINOSKY: That's shocking.

8 THE COURT: (Inaudible).

9 MR. NINOSKY: That's what he just said, but that isn't  
10 anywhere. That isn't documented anywhere in any other opinion  
11 that we've been given at this point.

12 MR. NINOSKY: That tends to contradict his claim that  
13 if -- he's saying there were no complaints. He was perfectly  
14 fine because, you know, whenever he complains it's documented in  
15 the file, so there was no complaint, meaning he had no pain,  
16 okay. So he was getting better. But that's not true given the  
17 extent of the disease, Your Honor.

18 This is a disease process we're talking about. He's  
19 an expert. He saw it for himself. And he testified that it was  
20 way advanced, that it's one of the worst he's seen and he's done  
21 hundreds, that it's among the top ten. So it's he's misleading  
22 the jury and he opened the door when he did that for us to now  
23 come in, right, and address the issue. I think it's proper  
24 cause, proper testimony.

25 MR. NINOSKY: Frankly, I'm offended that she's going

1 to say anything about me misleading the jury after some of the  
2 statements that have been made in this Court. However, I didn't  
3 open any door. The Court has already ruled on that issue.  
4 There was never a dispute that there were no complaints during  
5 those days. He made a big deal about that on direct.

6 THE COURT: (Inaudible).

7 MR. NINOSKY: Thank you.

8 (End of Sidebar)

9 THE COURT: Ladies and gentlemen of the jury, the last  
10 answer given by the doctor, I am going to strike that testimony,  
11 which means you may not consider it in any way.

12 Is there any juror that cannot follow that  
13 instruction? If so, please raise your hand?

14 UNIDENTIFIED JUROR: What was the last statement that  
15 he made?

16 THE COURT: Well, if you can't remember it, best not  
17 to remind you. So I'm going to assume you definitely can follow  
18 the instruction.

19 UNIDENTIFIED JUROR: If I can't remember, I won't.

20 THE COURT: Very well. Thank you very much.

21 Mr. Saleem, you may continue, sir.

22 BY MR. SALEEM:

23 Q The fact that Mr. -- Doctor, can an inmate who is in a jail  
24 walk to a hospital by himself?

25 MR. NINOSKY: Objection.

1 THE COURT: I'm sorry, sir.

2 MR. NINOSKY: Outside the scope.

3 MR. SALEEM: Can an inmate who is in a jail walk to a  
4 hospital by himself?

5 THE COURT: The question is whether a person in --

6 MR. SALEEM: In a jail can walk to a hospital by  
7 himself.

8 THE COURT: What is the relevance of that?

9 MR. SALEEM: it's to establish that he's in the care  
10 of the jail and under their control.

11 THE COURT: I think that's already established, but I  
12 certainly don't think that's anything that's rebutting anything  
13 put forward by cross.

14 MR. SALEEM: Okay. I'll move on, Your Honor. Okay.

15 THE COURT: The objection is sustained.

16 BY MR. SALEEM:

17 Q Okay. Then just the fact -- you were asked about whether  
18 or not you could understand Mr. Rodriguez when you communicated  
19 with him, is that fair?

20 A That is fair.

21 Q Okay. And when you were dealing with him you had already  
22 made a diagnosis as to what his condition was.

23 A Correct.

24 Q You had already performed an operation on him.

25 A Correct.

1 Q Okay. And you had already performed two operations on him.

2 A Correct.

3 Q Okay. Operations that you found to be one of the top ten  
4 that you've seen, correct?

5 A Correct.

6 Q Okay. And just because you were able to understand  
7 someone, does that necessarily equate that they are a good  
8 historian in terms of their complaints?

9 A Not necessarily.

10 Q Okay. And it was also mentioned that when Mr. Rodriguez  
11 went to the hospital that he was initially assessed for a  
12 possible bowel obstruction, is that right?

13 A Correct.

14 Q Okay. And Mr. Rodriguez didn't come straight from home.  
15 He came from being examined by other medical providers, right?

16 A Correct.

17 Q Okay. And usually when someone comes to another hospital  
18 setting they would get information from those medical providers  
19 as to the reason why that person is coming to the hospital, is  
20 that fair?

21 A Yes.

22 Q Okay. And I'm just going to show you what's been marked as  
23 PCM76, which is part of the medical records. According to this  
24 document which is from PrimeCare Medical, what is the reason or  
25 the -- this is a referral from PrimeCare to Reading Hospital, is

1 it not?

2 A Correct.

3 Q Okay. And based upon this document, what is noted as the  
4 chief complaint for Mr. Rodriguez needing to go to the hospital?

5 A Possible bowel obstruction.

6 Q Thank you. I have no further questions.

7 THE COURT: Thank you, sir.

8 Mr. Ninosky, any recross?

9 RECROSS-EXAMINATION

10 BY MR. NINOSKY:

11 Q And, Doctor, the Dr. Sha thought that that was reasonable  
12 when he worked him up, correct, for a small bowel obstruction?

13 A Correct.

14 Q And just a couple of things. You said that normal vital  
15 signs may not rule out disease process, correct?

16 A Correct.

17 Q But it also could be an indication of no disease process,  
18 fair?

19 A Correct.

20 Q Just like lab results.

21 A Correct.

22 Q In this particular case, labs were drawn, correct?

23 A Correct.

24 Q And that's appropriate.

25 A Yes.

1 Q And there was no indication of infection in those lab  
2 results, were there?

3 A They were slightly abnormal. The white count was normal.  
4 The bands were -- the neutrophils were slightly abnormal, but  
5 they were not grossly abnormal.

6 Q There you go. So we have -- again, we have lab work that  
7 was worked up that was reviewed in real time. It doesn't show  
8 really an abnormality, fair?

9 A Correct.

10 Q And the fever, infection can have or cause someone to have  
11 a fever, right?

12 A Correct.

13 Q At no point did he have a fever.

14 A Correct.

15 Q And, again, I know you said sometimes you may, sometimes  
16 you may not, but when you're trying to make decisions in real-  
17 time these are the types of things that you're looking at,  
18 correct?

19 A Correct.

20 Q Vital signs, lab results, you know, those types of things,  
21 fair?

22 A Correct.

23 Q Okay. Your Honor, that's it. Thank you.

24 THE COURT: Thank you, Counselor.

25 FURTHER REDIRECT EXAMINATION

1 BY MR. SALEEM:

2 Q Just the fact that there's no fever, is that enough of a  
3 basis for you to rule out a diagnosis of appendicitis?

4 MR. NINOSKY: Objection.

5 THE COURT: I think the doctor has already answered  
6 that question.

7 MR. SALEEM: Right. But it was just mentioned just  
8 right now on re --

9 THE COURT: I know it was. It's rare that I allow re-  
10 redirect, but it is your witness. But I think the doctor has  
11 already indicated that just because you don't have a fever does  
12 not mean you don't have an appendicitis, so I think it would be  
13 redundant.

14 BY MR. SALEEM:

15 Q Okay. And then just regarding the same type of fact that  
16 there is no elevation in a blood test, is that a hallmark  
17 necessary to rule out appendicitis?

18 A No.

19 THE COURT: And I think he testified to that before.

20 BY MR. SALEEM:

21 Q And why not, Doctor?

22 A Appendicitis --

23 MR. NINOSKY: Objection.

24 THE COURT: I'll overrule it and allow the answer.

25 THE WITNESS: Appendicitis can present in many ways

1 and the hallmark of appendicitis is abdominal pain and  
2 tenderness. And the prime way is with physical examination of  
3 the abdomen to rule out an abdominal process.

4 BY MR. SALEEM:

5 Q And Mr. Rodriguez was presenting with abdominal pain as of  
6 at least -- he was complaining of abdominal pain to a nurse on  
7 the 16th that it previously occurred on the 14th or 15th,  
8 correct?

9 A Correct. He experienced abdominal pain and exhibited  
10 tenderness.

11 THE COURT: Any re-recross?

12 MR. NINOSKY: Just one.

13 THE COURT: Sure.

14 FURTHER RECROSS-EXAMINATION

15 BY MR. NINOSKY:

16 Q And you're talking about the hallmark and the abdominal  
17 pain, you said it a little bit different in your report. You  
18 said the hallmark --

19 MR. SALEEM: Objection. Report not in evidence.

20 THE COURT: Excuse me.

21 MR. SALEEM: The report is not in evidence.

22 THE COURT: Yes, but he can cite it as prior statement  
23 of the doctor.

24 BY MR. NINOSKY:

25 Q The hallmark is the pain in the lower right side of the

1 abdomen, correct, sir?

2 A Yes.

3 Q That's the hallmark, the lower right quadrant, fair? Is  
4 that what you said in your report?

5 A Yes.

6 Q Okay. Nothing further, Your Honor.

7 FURTHER REDIRECT EXAMINATION

8 BY MR. SALEEM:

9 Q And on April 17th Mr. Rodriguez was complaining of pain to  
10 the lower right quadrant, correct, Doctor?

11 A Yes.

12 Q Okay.

13 THE COURT: Anything further of the doctor?

14 All right, Doctor. Thank you very much. You've been  
15 here for quite some time. You are excused, sir.

16 (Witness excused.)

17 (End of witness testimony 4:43 p.m.)

18 \* \* \* \* \*

19

20

21

22

23

24

25

26

C E R T I F I C A T I O N

I, Crystal Thomas, court approved transcriber,  
certify that the foregoing is a correct transcript from the  
official electronic sound recording of the proceedings in  
the above-entitled matter, and to the best of our ability.

*Crystal Thomas*

---

Crystal Thomas, CET-654

Date: June 9, 2017